DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 01716 the funeral directar, should be filed with after death. Page 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) PLACE OF DEATH o. COUNTY b. COUNTY MARYLAND arrel b. CITY OR TOWN (If autside corporate limits, write RURAL and give negrest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) THAMPSTEAD d. NAME OF HOSPITAL (If not in hospital, give street oddress) d. STREET ADDRESS OR INSTITUTION haurs 4. DATE OF DEATH NAME OF First Middle Month campletely filled DECEASED within 24 (Type or print) haurs after death rover AGE (In years lost birthdoy) UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 5. SEX 7. MARRIED NEVER MARRIED B. DATE OF BIRTH Months 410 WIDOWED [DIVORCED | 10a. USUAL OCCUPATION (Give kind of work done during mast af working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote ar foreign country) 12. CITIZEN OF WHAT COUNTRY? ond carban 72 13. FATHER'S NAME physician within requires that the death certificate remave 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT event, attending please 18. CAUSE OF DEATH PART I. DEATH pup þ crematian, ar remaval, Conditions, if ony, has been signed gove rise to imm couse (o), stoting the lying couse last. the burial-transit CATION PART II. OTHER 20a. ACCIDENT WAS certificate (IF EITHER, NOTIFY MI ta burial, MEDICAL 20c. TIME OF INJURY use Hour o. m. After this p. m. far 24. Certify that saw the deceased RECTOR: 22a. SIGNATURE Board HYSICIAN'S NAME ype) TO HOSPITA page 3 shi the State E TO FUNER BURIAL, CREMATION BREMOVAL-(Specify) 24 FUNERAL DIRECTOR'S

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Day

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e. IS RESIDENCE

Hours

YES NO DE

Year

1962

[Enter anly ane couse per line fo (o), (b), and (c).]	INTERVAL BETWEEN
WAS CAUSED BY: (O DECLARY (OCCURSION)	Suddenly
which (b) Types leverie Carlio Vascular Desire	>
under. DUE TO	_
(c)	TALL TO MAKE AUTORS
SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART	PERFORMED?
JNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) BAUSE OF DEATH DICAL EXAMINER)	
Month, Doy, Year 20d. INJURY OCCURRED While Not while of werk of work	County) (Sto
1) (this haspital) attended the deceased fram. May 11 1960, to Debug 9, 1960 and an the alive an Declar 1962 and that death accurred in P. M. from the cause and an the	
M.D. PHYS. MED. DIRECTOR STAFF PHYS	22b. DATE SIGNI
of E. Bush MD. HAMPSTEAD Ma	ryland
23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county)	(State)
2/12/62 Westminster Cemetery Westminster, Car.	roll Co. M
IGNATURE Jampstead Md. 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIG	

MARYLAND STATE DEPARTMENT OF HEALTH

es b Charles Ecrelded Films Trade care I may prested this land . How fitted the

CERTIFICATE OF DEATH Rea. Dist. No PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY b. COUNTY MARYLAND b. CITY, OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN of putside corporate limits, write RURAL and give nearest town) RUBAL and dive negrest town) d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? INSTITUTION YES NO NAME OF Middle 4. DATE Last Day DECEASED (Type or print) DEATH S. SEX 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED 9. AGE (In years last birthday) Months Doys Hours WIDOWED | DIVORCED USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE State of 12. CITIZEN OF WHAT COUNTRY? during most of warking life, even If retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN N. 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address (If yes, give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gove rise to immediate DUE TO cause (a), stoting the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH) BUT NOTE RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) Day, Year (County) (Stote) foctory, street, office bldg., etc.) Hour a. m. While Nat while at wark at work p. m 1934, ta Febr 1 94, 1962 that I last saw the deceased 21. I certify that I attended the deceased fram , and that death occurred at 8A M, from the causes and an the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE_ PHYSICIAN'S NAME (Type) 111170 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22d. LOCATION (City, town, or county) MAME OF CEMETERY OR CREMATORY -(State) he 24b. REGISTRAR'S STGNATURE 24g. KEC'D 8Y REGISTRAR FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** arthur S. Thous

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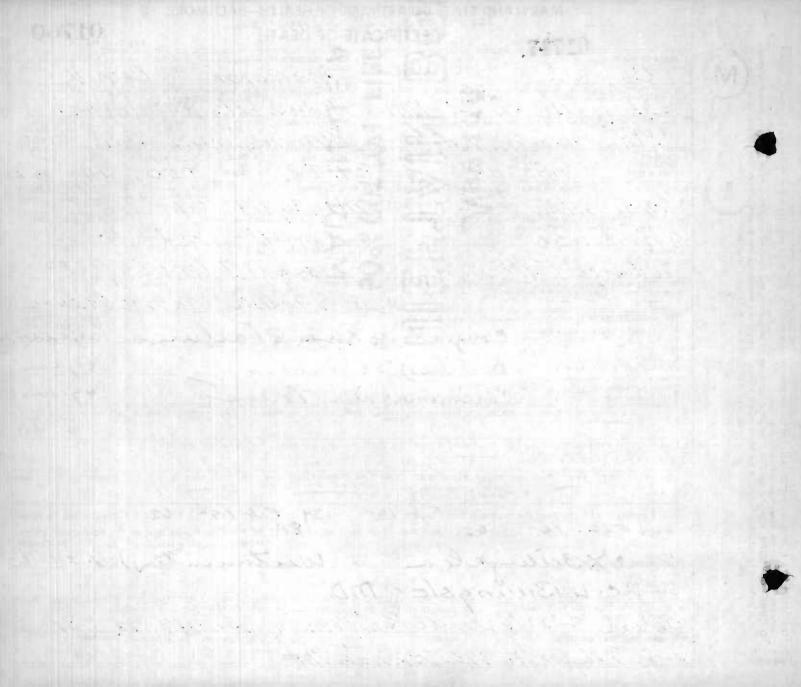
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

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	o. COUNTY				2. USUAL RESII	DENCE (Where dece			dence before ad	lmissian)
		roll		MARYLAND		aryland	b. C	OUNTY	Carroli	1
	b. CITY OR TOWN (If RURAL ond give nee	outside corporate lim	its, write c. LENGTI	H OF STAY IN 16	c. CITY OR 1	OWN (If outside co	orporote limits,	write RURAL o	nd give nearest	tawn)
F	uralUn		ge Thre	ee Wks.	XRural	West	minste	er		
	d. NAME OF HOSPITA	AL (If not in haspital,	give street oddress)		d. STREET A	DDRESS			e. IS	RESIDENCE
	OK INSTITUTION				R. I). # 5				S NO I
3.	NAME OF	Fi	rst	Middle	Las		ΓE	Month	Day	Year
	DECEASED (Type ar print)	HARLES		C.	BARNES	OF DEA	ATH F	еь.	8	1962
5.	SEX	6. COLOR OR RACE	7. MARRIED NE	VER MARRIED	B. DATE OF BIRTH	1	9. AGE (II	years IF UN	DER 1 YEAR IF U	INDER 24 HRS.
1	falle	White	WIDOWED	DIVORCED [Februar	y 10.18	75 last bir	yrs. Mont	hs Days Ho	urs Min.
	. USUAL OCCUPATIO	N (Give kind af warking life, even if retired	dane 10b. KIND OF B	USINESS OR INDU	STRY 11. BIRTHPL	ACE (State or foreig	n country)	12.	CITIZEN OF WH	AT COUNTRY?
Bo	dy & Fen			tired)	Mar	vland			U.S.	A.
13.	FATHER'S NAME	401	VII. 0		14. MOTHER'S	MAIDEN NAME				
	James B	arnes			Ki	tty Sh	ipley			
	WAS DECEASED EVER	IN U. S. ARMED FOI		CURITY NO. 17, II	NFORMANT			Address		
I I I	is, no, or unknown) (i	f yes, give war or dates of	216-05-	-6530 Mr	s. Leis	hton Ha	iflev	Sam	e as #	1
-	18. CAUSE OF DEAT	TH [Enter only one of	ouse per line for (a), (_		- N		INTERVA	L BETWEEN
		H WAS CAUSED BY:	1.+	asc loss	tic Car	disum.	· · · ban-	Disco	1	ND DEATH
	4-2	IMMEDIATE CAUSE (c		03000			-cer-		0	
	Canditians, if on	y which)								
	gave rise to in	mediate Due To								
	lying couse last.	ne <u>under-</u>								
Z		ER SIGNIFICANT CON	DITIONS CONTRIBUTI	ING TO DEATH BUT	NOT RELATED TO	THE TERMINAL DIS	EASE CONDITI	ON GIVEN IN	PART 1(a) 19. W	AS AUTOPSY
CERTIFICATION	Ca	Kinoma	at the	Prosta-	te				PE	RFORMED?
TIFIC	20a. ACCIDENT WAS	S UNDERLYING [7]	206 DESCRIBE HOW	/ INJURY OCCURRE	D. (Enter noture o	f injury in Part I or	Port II of item	18.)		
	(IF EITHER, NOTIFY	CAUSE OF DEATH MEDICAL EXAMINER)								
MEDICAL	20c. TIME OF INJURY	Month, Doy, Ye		£-	ACE OF INJURY (Home, farm, 20f.	(City or town)		(Caunty)	(Stote)
MED	Hour o.m. p. m.	19	While Not v	Aume	ciory, sireer, dirice	blug., elc.)	,			
1	21. I certify that	(I) (this haspita	1) attended the a	deceased fram	1/19/62	19	0 2/8	162 1	9, that (1) five) last
	saw the decease	- 1 · 1 ·	15/62 19			815 PM, fr	am the cau	1	,	
	220. SIGNATURE	10	4	- Condition					,	22b. DATE
	1	+ Cana	10		M.D. PHYS.	MED. DIRECTOR	STAFF PHYS.		2/8/	C2 SIGNED
	22c. PHYSICIAN'S		0		22d. ADDRE	SS ,	11 .	4	1	
	IANWE PROPERTY	JiH. C+	PRICOTE		1185	MAIN ST	Uni	ON BRI	OGE,	Ma
23	BURIAL, CREMATION	N, 23b. DATE THERE	OF 23c. NAA	ME OF CEMETERY C	R CREMATORY	23d. LC	CATION (City	town, ar coun	ty)	(Stote)
	Burial (Specify)	Feb. 10,	1962 Ebe:	nezer Ce	emetery	Wir	nfield	, Mary	rland	
24.	FUNERAL DIRECTOR'S	-	ADDI	RESS		25a. REC'D BY RE	GISTRAR 25	b. REGISTRAR'S		
4	C. M. Wa	iltz. Box	241. Sy	kesvill	e. Md.	DATE 12	162	Chilling,	8. Thous	U.Seria

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ARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET. BALTIMORE 1. MARY CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. COUNTY b. COUNTY Carroll MARYLAND Balto, City b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL and give neerest town) write RURAL and give nearest town) Sykesville 12yrs.3mos.26days Baltimore d. NAME OF HOSPITAL OR INSTITUTION (if not In hospital, give street eddress) e. IS RESIDENCE Formerly ON A FARM? Springfield State Hospital Ferndale Avenue YES NO Middle DECEASED Ethel (Type or print) Amelia Barnes DEATH February 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Female WIDOWED [DIVORCED 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? BIRTHPLACE (County & 1 e. or fore an country) done during most of working life, even if retired) Factory worker Maryland U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Then please Francis M. Barnes Annie Rebecca Hardy 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unkown) | (Ifyes give wer or detes of service) No Springfield Hospital Records 18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Septicemia Days IMMEDIATE CAUSE (e) DUE TO Pulmonary abscess Conditions, if eny, which Weeks geve rise to immediate cause DUE TO (e), steting the underlying PART U. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY Psychosis with cerebral arteriosclerosis. PERFORMED? YES X NO 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Pert I or Pert II of item 18,) 20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED | 20e, PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) (Stete) fectory, street, office bldg., etc.) Hour a.m. While Not While et work | et work | 21. I certify that (I) (this hospital) attended the deceased from....October...15, 19.49 to February...11 19.62 that (I) (we) last saw the deceased alive on February 11.19.62., and that death occured a 2.28 Mirom the causes and on the date stated above. ATTENDING PHYS. DIRECTOR PHYSICIAN'S 22d. ADDRESS Agustin delCampo, M.D. Springfield Hospital, Sykesville, Maryland ector, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, 0.4 8 REMOVAL (Specify) Raltimore, Maryland Burila Mt. Olivet Cemetery 250. REC'D BY REGISTRAR | 256. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) CG / SOATFEB 1 3 '62 Circhary S. Thous

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attending physician. as been signed by the

DIRECTOR:

RYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAR' CERTIFICATE OF DEATH 01720 funeral should within 24 hours after 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. COUNTY b. COUNTY Carroll by the and 2 death. Carroll MARYLAND Maryland b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give neerest town) Finksburg Sykesville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS a. IS RESIDENCE ON A FARM? YES NO Springfield State Hospital executed 3. NAME OF 4. DATE Middle Month complet DECEASED OF Sally (Sarah) (Type or print) DEATH Ann Knouse BARNES February 19 62 9. AGE (In years | IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH IF UNDER 24 HRS. last birthday) Months white DIVORCED female WIDOWED [please rem 10a. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) U.S.A. Housewife Pennsylvania
14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME e attending I Then please John Knouse, dec. Jane Mann, dec. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unkown) | (If yes give wer or detes of service) Springfield State Hospital Records INTERVAL BETWEEN 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Arteriosclerotic heart disease. years IMMEDIATE CAUSE (e) DUE TO Arteriosclerosis, generalized. Conditions, if any, which years gave rise to immediate cause DUE TO (a), steting the underlying Pulmonary tuberculosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? ulmonary tuberculosis, minimal: active with cerebral arteriosclerosis, without qualifying phrase NO K 20b. DESCRIBE HOW INJURY OCCURED. (Enler neture of injury in Pert I or Part II of item 1B. OR CONTRIBUTING CAUSE OF DEATH MEDICAL 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, term, 20f. (City or town) (County) (Stete) 20c. TIME OF INJURY Month, Dey, Yeer TOR: After fectory, street, office bldg., etc.) While Not While Hour a.m. et work et work 21. I certify that (I) (this hospital) attended the deceased from 1-27-61 2-4-62...., 19....., that (I) (we) last ed the deceased from that (1) (we) last 1, 19......, 19....., that (1) (we) last 2, 2, 3, 19......, 19....., that (1) (we) last 2, 3, 19......, 19......, 19......, 19......, 19...... saw the deceased alive on.....2-4-62 22e. SIGNATURE SIGNED ATTENDING MED. DIRECTOR PHYS. 22d. ADDRESS 22k, PHYSICA FUNE Agustin del Campo. M.D. Sykesville, Maryland filed v 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county). (Stete) 23a. BURIAL, CREMATION, 23b. 0 = 3 REMIDVAL (Specify) 25a, REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR'S SIGNATURE VR A1S (4) 15M 7/61 Chilling S. House

The state of the s E F THE POPULAR SE CONFIDENCE TO

d in by the funeral rages 1 and 2 should The law requires that the death certificate be executed within 24 hours after TO HOSPITAL OR ATTENDING PHYSICIAN: the law requires that the death certificate be executed within 2 death. Prof. may be retained by the hospital or attending physician.

The TUNEXAL DIRECTOR: After this certificate has been signed by the attending physician and completely din director, page 3 should be detacted for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after OR ATTENDING PHYSICIAN: TO HOSPIT

> VR A15 (4) 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

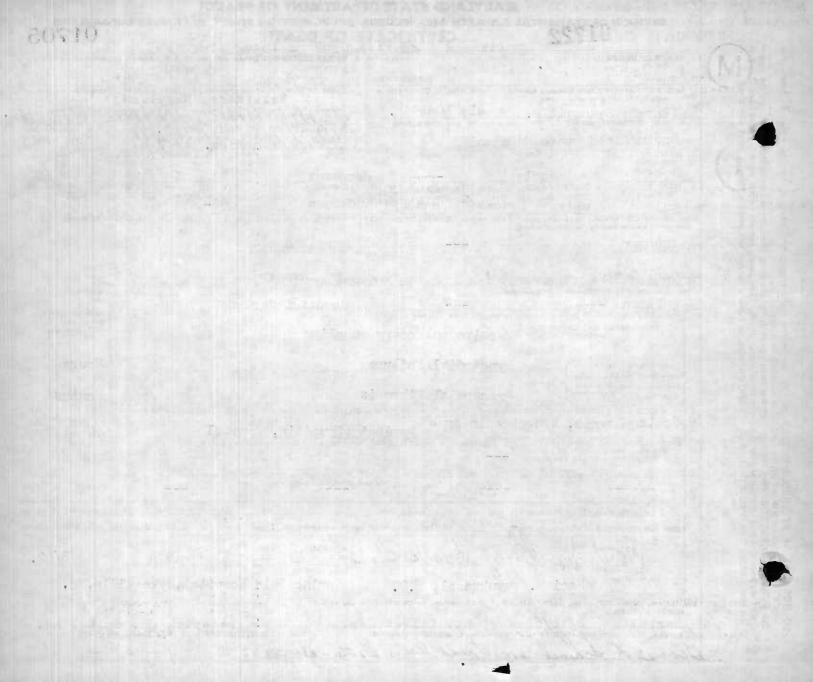
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH CERTIFICATE OF DEATH カオフラオ

1. PLACE OF DEATH a, COUNTY	2. USUAL RESIDENCE (Where deceased lived, If institu	ition: Residence before admission)
Carroll	LAND Maryland b. COUNTY	ity Bolto.
b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STA		At and give neerest town)
write RURAL end give neerest town) Stylesty 112		222
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street addr.	Darcinore 12	O. S.A. IS RESIDENCE
o. Name of Nostrice or world for the mospher, give street address	G. STREET ADDRESS	ON A FARM?
Springfield State Hospital	2823 Linwood Avenue	YES NO
NAME OF First Middle DECEASED	Lest 4. DATE Month	Dey Yeer
(Type or print) Stella	Bartnik OF 2	11 19 62
. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIE		NDER 1 YEAR IF UNDER 24 HRS.
The same of the sa	Moi Military) Moi	nths Deys Hours Min.
Female White WIDOWED DIVORCED Da. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR	LINOVEMBEL J. 1807	A CIVIZON OF MULAY COUNTRY
Da. USUAL OCCUPATION (Give kind of work one during most of working life, even if retired)	R INDUSTRY 11. BIRTHPLACE (County & State, or foreign country)	2. CITIZEN OF WHAT COUNTRY
Housewife -	Germany	U.S.A.
B. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	- O D O C C
. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO	O. 17. INFORMANT Address	
es, no, or unkown) (Ifyesgivewerordetesofservice)		
No	Springfield Hospital Records	Transport of the second
18. CAUSE OF DEATH Enter only one cause per line for (e), (b), and (c	c).J	INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY: Septicemia		days
DUE TO Tomas infected		
Conditions, if eny, which (b) Large infected	pressure.sores	weeks
geva rise to immediate cause (e), stating the underlying DUE TO		
cause last. (c)		
	H BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN	PART 1(e) 19. WAS AUTOPSY
C D C with comphant amtonional	Parkinsonism.	YES Y NO
C.B.S. with cerebral arteriosclero	OSIS WITH PSYCHOTIC PERCTION OCCURED, (Enter neture of injury in Pert I or Pert II of item 1B.)	YES X NO
C.B.S. with cerebral arteriosclero 200. ACCIDENT WAS UNDERLYING 200. DESCRIBE HOW INJURY OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	OCCURED. (Enter neture of injury in rem) or rem it of them its.)	
20c. TIME OF INJURY Month, Dey, Yeer	20e. PLACE OF INJURY (Home, farm, 20f. (City or town)	(County) (State)
Hour e.m. While Not While	fectory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the deceased	d from 1-6- 3962 to 2-11	., 19.52, that (I) (we) la
saw the deceased alive on 2-11 1962, a	and that death occured at	on the date stated above
22e. SIGNATURE	,	22b. DATE
anistin del anis	ATTENDING MED. STAFF	2-11-1962
22c. PRYSICIAN'S	M.D. PHYS. DIRECTOR PHYS.	
NAME (IVDW)		
Agustin del Campo, M.D.		I, Sykesville,
	EMETERY OR CREMATORY 23d. LOCATION (City, town or	county) (State)
REMOVAL (Specify) 2-15-62 Rean Cel	SOMERSET P	
FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a, REC'D BY REGISTRAR 25b, REGISTR	AR'S SIGNATURE
wm.Cook Blight Inc. 6009 Harford Rd.		of S. Hama
mi. cook bitght the. booy harrord kd.	Datoo 149 Water 1 002	13 AL. THAMA



711/1	1,	LACE OF DEATH	ems 2 & 23 Fi	2. USUAL RESIDENC	E (Where daceasad lived, If		a befora edmission
CASCE A		Carroll	MARYLAND	a. STATE Marvlan	b. COUN	Md.	34 1.4
6 2		city OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16		outside corporate limits, write	e RURAL end give no	earest town)
6 9			41y 10m 9da.	Browshit to	this hashite	l/from/Ba	will out / Has
9 15		(Rural) Sykesville, I. NAME OF HOSPITAL OR INSTITUTION (If not in I	hospital, giva straat address)	d STREET APPRESS	given for nt	17 + + + + + + + + + + + + + + + + + + +	a. IS RESIDENCE
oni		Springfield State Hospi	tal	tyle of /so	BT1777111111111111111111111111111111111	5 W.	YES NO
	3.	NAME OF First	Middla	Last	OF MULDESH	y St. Day	Year
		Type or print) Karl	====	Beaumont	DEATH 2	8	19 62
	5.	6. COLOR OR RACE 7. MAR	RIED NEVER MARRIED X 8	. DATE OF BIRTH	9. AGE (In years last birthday)		IF UNDER 24 HRS.
2.		male white wipo	WED DIVORCED	unknown	60-? yrs.	Months Days	Hours Min.
	10a do	USUAL OCCUPATION (Give kind of work during most of working life, even if retired)	KIND OF BUSINESS OR INDUSTR	RY 11. BIRTHPLACE (County	& State, or foreign country)	12. CITIZEN OF	WHAT COUNTRY
				Marvland		USA	
	13.	FATHER'S NAME		14. MOTHER'S MAIDEN N	AME	own.	
		Carl Geseck		Mand Shennar	പ്		
	15. (Ye	Carl Geseck WAS DECEASED EVER IN U.S. ARMED FORCES? 1 , no, or unkown) (Ifyasgivawarordalasofservice)	6. SOCIAL SECURITY NO. 17.	INFORMANT	Addrass		
		unknown		Hospital Re	ecords		
		1B. CAUSE OF DEATH [Enter only one cause pa	or line for (a), (b), and (c).]			INTE	RYAL BETWEEN
-		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mas	ssive pulmonary	embolism		Mi	nutes
		DUE TO					
		Conditions, if any, which (b) My(cardial Failure			Но	ours
		(a), stating the underlying DUE TO	21 2 21 -1				
		(-)	cardial Fibrosi				nths
2	ON N	Schizophrenia, hebephre	nic time			'EN IN PART 1(a) 19	PERFORMED?
0	3		Puruen	it sinusitis,	frontal	YI	ES NO
		20b. CODENT WAS UNDERLYING (CAUSE OF DEATH OF SITTED CAUSE OF SITTED CAU	ESCRIBE HOW INJURY OCCURED), (Entar natura of Injury In Pa	ri T or Pari II of Itam IS.)		
	MEDICAL		d. INJURY OCCURRED 20e. PLA	CE OF INJURY (Homa, farm, tory, straat, office bldg., etc.)	20f. (City or town)	(County)	(Stata)
		T_A .	ork et work				
	MED	p.m. 19 at v	or work				
	MED	21. I certify that (I) (this hospital) atte	anded the deceased from	19) a, #	, 19, th	at (I) (we) las
	MED	21. I certify that (I) (this hospital) atterates the deceased alive on	anded the deceased from	death occured at 8.:	a inc.	, 19, th	e stated above
	MED	21. I certify that (I) (this hospital) atte	anded the deceased from	death occured at D.:	3.00, from the causes	, 19, th and on the dat	e stated above
	MED	21. I certify that (I) (this hospital) attessaw the deceased alive on	anded the deceased from	ATTENDING ME PHYS.	3.00, from the causes	, 19, th and on the dat	e stated above
	MED	21. I certify that (I) (this hospital) attered as we the deceased alive on	ended the deceased from	ATTENDING ME PHYS. DIF	D. STAFF PHYS.	and on the dat	e stated above 22b. DATE SIGNED 2/8/62
1		21. I certify that (I) (this hospital) attered alive on	ikunsal, M.D.	ATTENDING ME PHYS. DIF 22d. ADDRESS Springfiel	D. STAFF PHYS. d Hospital, Sy	and on the dat Wesville,	e stated above 22b. DATE SIGNED 2/8/62.
	23a	21. I certify that (I) (this hospital) attered as we the deceased alive on	ended the deceased from	ATTENDING ME PHYS. DIF 22d. ADDRESS Springfiel	D. STAFF PHYS.	and on the dat Wesville,	e stated above 22b. DATE SIGNED 2/8/62
	23a	21. I certify that (I) (this hospital) attered the deceased alive on	ikunsal, M.D. 23c. NAME OF CEMETERY Mt. Olivet	ATTENDING ME PHYS. DIF DIF COR CREMATORY	D. STAFF ECTOR PHYS. D d Hospital, State Control City, to	wn or county)	e stated above 22b. DATE SIGNED 2/8/62 Md (State)
	23a	21. I certify that (I) (this hospital) attered and the deceased alive on 22a. SIGNATURE 22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF LEMOVAL (Spacify)	akunsal, M.D.	ATTENDING ME PHYS. DIF DIF COR CREMATORY	AM, from the causes D. STAFF ECTOR PHYS. d. Hospital, SJ 23d. LOCATION (City, too BY REGISTRAR 25b. REC	wn or county)	e stated above 22b. DATE 2/8/62 Md (State)

MARYLAND STATE DEPARTMENT OF HEALTH



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAR 01723 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before edmission) e. COUNTY b. COUNTY Carroll MARYLAND Maryland b. CITY OR TOWN (if outside corporate limits. c. CITY OR TOWN (If outside corporete limits, write RURAL end give nearest town) c. LENGTH OF STAY IN 16 write RURAL and give nearest town) Baltimore 11 Sykesville 4mos 28day: 4mos.28days d. STREET ADDRESS a. IS RESIDENCE ON A FARM? Springfield State Hospital YES NO TH 3350 Chestnut Avenue DATE DECEASED OF (Type or print) DEATH Ten Belchner 19 62 February and cor carbon nt, withis 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months | Devs Male WIDOWED DIVORCED T October 18, 1894 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Spray Painter U.S.A. Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME George Andrew Belchner Rosa McCarthy 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (If yes give we ror detes of service) Springfield Hospital Records 218-10-3844 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (e) Years DUE TO (b) Generalized arteriosclerosis Years geve rise to immediate cause DUE TO (e), steting the underlying so last.

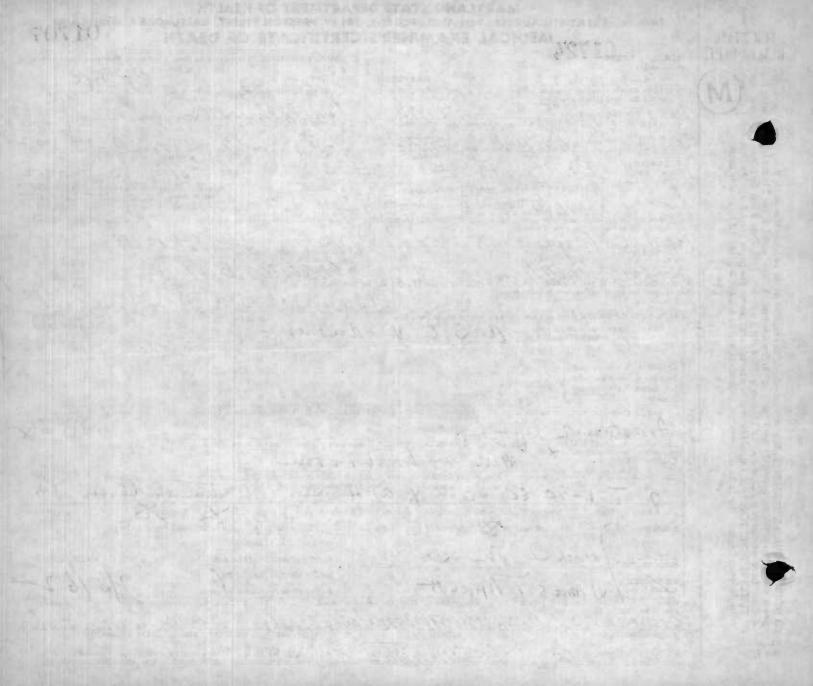
(c) Far advanced bilateral pulmonary T.B., Active

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY CERTIFICATION PERFORMED? Deferred. 002 NO T 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18.) 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) fectory, street, office bldg., etc.) While Not While Hour e.m. et work et work DIRECTOR: 21. I certify that (I) (this hospital) attended the deceased from 9-8-..., 19.61 to 26-..., 19.62, that (I) (we) last 22e. SIGNATURE ATTENDING SIGNED DIRECTOR PHYS. M.D. FUNERA 22d. ADDRESS 2/2c. PHYSICIAN'S (Type) Springfield State Hospital, Sykesville, Md. Agustin del CampoV 23d. LOCATION (City/town or county) 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION. | 23b. P G 0 24 FUNERAL DIRECTOR'S SIGNATURE 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE VR A15 (4) 1SM 7/61 DATE FEE 1 3 '62 Chiling & Thrus

11 5 11 1 1 A STATE OF THE STA The second of th

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAN FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. 1. PLACE OF DEAT 2. USUAL RESIDENCE (Where decaesed lived, If institution: Residence before admission) a. COUNTY a. STATE b. COUNTY iles. MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 OR TOWN outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) INSTITUTION (if not in hospital, giva street addrass) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? YES NO Z NAME OF DECEASED OF (Typa or print) 6. COLOR OR RACE 7. MARRIED 9. AGE (In years | IF UNDER 1 YEAR DATE OF BIRTH IF UNDER 24 HRS. NEVER MARRIED last birthday) Months Days Hours WIDOWED A DIVORCED SUAL OCCUPATION (Giva kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12 BIRTAPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, aven i retired) Give Pag WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 1 17. INFORMAN (Yes, no, or unkown) | (If yes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Office Conditions, if envowhich (b) gava rise to immadiate causa DUE TO (a), stating tha undarlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO 0 20a. EXTERNAL CAUSE WAS DESCRIBE HOW INJURY OCCURED, (Entar natura of injury in Part I or Part II of item 18,) CAUSE OF DEATH. e 3 buri CAL 2Dd. INJURY OCCURRED | 2Da. PLACE OF INJURY (Homa, farm, 20c. TIME OF INJURY Month, Day, Yaar 20f. (City or town) (County) S. factory, street, office bldg., etc.) Whila Not Whila at work - 20 10 5 Dat work 21. I certify that I took charge of the remains described above, held an Autopsy and in my opinion Inspection Inquiry 0 0 Undetermined manner death resulted from: Natural causes Suicide Homicide Accident should be forward FUNERAL DIRE CHIEF MEDICAL EXAMINER the ACTUAL designated ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER EXAMINER'S NAME (Typa) Addrass (Streat, city, town, or county) please 4 shou O FUN 22a. BURIAL, CREMATION, NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country (Stata) 24a. REC'DAY REGISTRAR 246. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VS. A15ME arthur & Thave 5M 7/59 DATE

MARYLAND STATE DEPARTMENT OF HEALTH



1	MARYLAND STATE DEPARTMENT OF HEALTH
END STATE	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1708
HEALTH DEPT	01/25
×8 ±0)	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. COUNTY b. COUNTY b. COUNTY
Pagry Files.	b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown)
ित्र हे हु हु । जिस्से हु हु ।	write RURAL end give neerest town)
dire dire	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS 1 o. IS RESIDENCE
Boar d	HORE- 505 E. MAIN STREET 505 E. MAIN ST. YES NO X
fur faine Stat eath	3. NAME OF First Middle Last 4. DATE Month Day Year
If a the the	(Type or print) PAIRICIA ANN BOONE DEATH FEB X 1962
Signal Si	S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Months Dave Hours Min.
and and 22 mand 22 man	WIDOWED DIVORCED VAN. 23, 1/62 yrs.
s affi ge ge and and 72 h	10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 11. All 1
nour 1. Pa 1. Pa 1. Pa 1. Pa	13. FATHER'S NAME
PM3 PM3 pag with	PAUL C. BOONE NETTIE R. STONESIFER
ent Girling	TO WAS DECEMBED AND THE ADMINISTRATION OF THE PARTY OF TH
th formit.	(Yes, no, or unkown) (Ifyes giva wer or dates of service) FATHER PAUL C. BUONE WESTMINSTER, MI
lter Will per n an	18. CAUSE OF DEATH [Enter only one causa par line for (e), (b), end (c).]
exe llong ansi nd i	PART I. DEATH WAS CAUSED BY; Multiple Conjenital abnormality - 16 days.
i bence a sel, a	DUE TO
oulo fri Offi	Conditions, if any, which (b)
e sh er's as a	geve rise to immediate cause (e), stating the underlying DUE TO
ifical sed a	cause last. (c)
Exa exion	PERFORMED?
wor wor Jical Jid E	YES NO YES 20e. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part II or Part II of item 18.)
the the should should be s	PRIMARY OF CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTION CONTRIB
iting hief burl	ZOc. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, 20f. (City or town) (State)
Pag Pag	20c. TIME OF INJURY Month, Dey, Yeer Hour a.m. p.m. 19 Annual Month, Dey, Yeer at work 19 at work 19 at work 19 Annual Month, Dey, Yeer at work 19 Annual Month, Dey, Yeer 20d. INJURY OCCURRED factory, street, office bldg., etc.)
D. T. Cate	21. I certify that I took charge of the remains described above, held an Autopsy . Inspection , Inquiry and in my opinion
THE CONTRACT	death resulted com: Natural causes . Accident . Suicide . Homicide . Undetermined manner
Pare Age age	CHIEF MEDICAL EXAMINER
ME the forw forw	SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER DATE SIGNED
Sign Ra	EXAMINER'S TO 2/8/62
berugen in should be its designation of the state of the	NAME (Type) AMES Address (Streat, city, lown, or county) 228. BURIAD CREMATION, 22b. DATE THEREO 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (State)
O DE Please 4 sho O FU or its	BURIAL 2/9/62 KRIDER'S CEMETER WESTMINSTER, MD.
HH	23. JUNERAL DIRECTOR 1/1/1 ADDRESS . A 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE
VS. A15ME 5M 7/59	James D. Safflet West must of Md DATEFE 9 162 Cultury S. Krus
22,	(1 / 1 / 2 / 1 / 1 / 2 / 1 / 2 / 2 / 2 /

Water Statement Comments of the Comments of th The state of the s The state of the s CARREL NEWS NEWS Tropped of Stanford APPLICATION OF THE HEALTH WASHINGTON ALLEY BOOK

funeral The law requires that the death certificate be executed within 24 hours after in by ir use as the burial-transit permit. Then please remove carbon papers. Pages prior to burial, cremation, or removal, and in any event, within 72 hours after is certificate has been signed by the attending physician and completely for use as the burial-transit permit. Then please remove carbon papers. may be retained by the DIRECTOR: After this 3 should be detached for be filed with the State death. Part TO FUNERAL director, page TO HOSPI

VR ATS 15M 7/61 3.

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10а do 13.

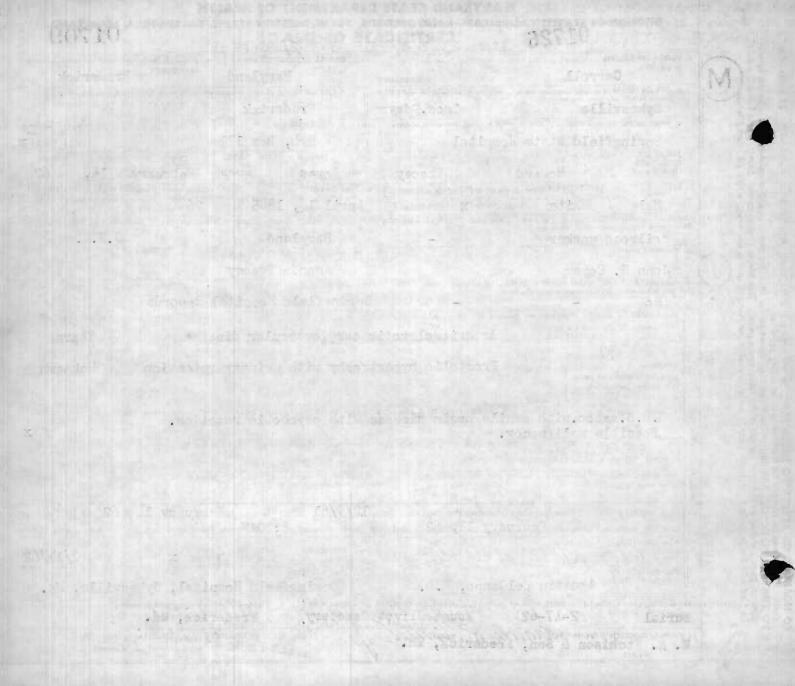
	DIVISION	of STATISTICAL	MAR RESE	YLAND STA ARCH AND R CERTII	ECORD	EPARTM! 5, 301 W. F	RESTO	F HEAN STRE	LTH ET, BALTIM	ORE 1,	MAR	YLANE		
1.	PLACE OF DEATH		Ite			m G307	EATH 2/20/	/62	iwk deceased lived, If	institution	Residen	e before e	dmission	
	a. COUNTY Ca	/LAND	e. STATE		rland	b. COUN	JTV _		rick					
	b. CITY OR TOWN (if	f outside corporate limits give nearest town)		c. LENGTH OF ST.	AY IN 16	c. CITY OR	TOWN (H	outside co	rporate limits, writ	RURAL	nd give i	neerest tow	n)	
	Sykesvi			2mos.90	lays	F:	rederi	ck		1	OX	-2		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET							ESIDENCE A FARM?	
	Springf	ield State	Hospi	ital		R ₇	#4, Bo	ox 17	3			YES _	NO K	
3.	NAME OF DECEASED	First		Middle		Last	4	. DATE	Montl	1	Day	Yee		
	(Type or print)	Howard		Trace	y	Boye:	r	DEAT	н Febr	uary	14	, 19	62	
5.	SEX	6. COLOR OR RACE	. MARRIE	D NEVER MARRI	ED 8.	. DATE OF BIRTH			9. AGE (In years last birthday)			IF UNDER		
	Male	White	WIDOWE			April 1	5, 188	35	76 yrs.	Months	Days	Hours	Min.	
10a	B. USUAL OCCUPAT	ION (Give kind of work		IND OF BUSINESS O	R INDUSTR	Y 11. BIRTHPLA	CE (County	& Stete, c	or foreign country)	12. C	ITIZEN O	F WHAT	OUNTRY?	
	done during most of working life, even if retired) Railroad Worker					Maryland						U.S.A.		
13.	FATHER'S NAME					14. MOTHER'S	MAIDEN NA	AME						
	John H.	Bover				Ama	nda Tr	acey						
	WAS DECEASED EV	ER IN U.S. ARMED FORCE		SOCIAL SECURITY	10. 17. I	NFORMANT			Address			75		
	No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-	5	Springfi	eld Ho	ospit	al Recor	ds				
		EATH [Enter only one of	ause per l	ine for (e), (b), end	(c).]							ERVAL BET		
		H WAS CAUSED BY: IMMEDIATE CAUSE (e)	Ar	terioscle	rotic	cardiov	ascul	ar di	sease			Years		
	1422 1	DUE TO												
	Conditions, if eny	, which) (b)	Pr	ostatic h	ypert:	rophy wi	th ur	inary	retenti	on	Ţ	Jnkno	wn	
	geve rise to immedi (e), steting the u	DIJE TO												
	ceuse lest.	(c)												
Z	PART II. OTHER	SIGNIFICANT CONDITI	ONS CON	AND OT DAITUEST	TH BUT NO	T RELATED TO TH	E TERMINA	L DISEASI	CONDITION GIV	EN IN PA	RT 1(a) 1	9. WAS A	UTOPSY	
ATI		le malignano		pram ur	scase	MTOIL DS	y chou.	TC Te	sac oron.				NO St	
CERTIFIC	20e. ACCIDENT W. OR CONTRIBUTING			CRIBE HOW INJURY	OCCURED	. (Enter neture of	injury in Pe	rt I or Pert	II of item 1B.)					
MEDICAL	20c. TIME OF INJU Hour a.m. p.m.	RY Month, Dey, Yeer	20d. While			CE OF INJURY (Hory, street, office		20f. (C	ity or town)	(Co	unty)		(Stete)	
	21. I certify i	hat (I) (this hospita	l) atten	ded the decease	ed from	12/5/61), to	Eebruary	1.14 19	9.62, 11	hat (I) (we) last	

CERTIFICATION MEDICAL saw the deceased elive on TEDRUARY 12,1902..., end that death occured an 200 AM from the causes and on the date stated above.

2/14/62 22e. SIGNATUR MED. DIRECTOR STAFF PHYS. X PHYS. 22c. PHYSICIAN'S 22d. ADDRESS

Agustin delCampo, M.D. Springfield Hospital, Sykesville, 23a. BURIAL, CREMATION, 23b. DATE THEREOF OR O

258. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE CATALOG & Trans M. R. Etchison & Son,



TO HOSP 4. OR ATIENDING PHYSICIAN: Into law requires may be about the process of OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

TO HOSPAR

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 01710

1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. COUNTY Carroll MARYLAND	•. STATE Maryland b. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporete limits, write RURAL and give nearest town)
Rural-Sykesville 6 mo. 15 dys	Baltimore 34, Maryland 03x - 2
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS o. IS RESIDENCE ON A FARM?
Springfield State Hospital	9039 Simms Avenue YES NO A
3. NAME OF First Middle DECEASED	Last 4. DATE Month Day Year
(Type or print) Alice Elizabeth	Burgan DEATH 2 27 19 62
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8	DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
female white widowed to DIVORCED	12/13/79 82 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	Y 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? Maryland USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
David Grover	unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. I	NFORMANT Address
(Yes, no, or unkown) (Ifyesgivewarordatesofservice) NO Spr	ingfield Hospital records - Sykesville, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]	INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (*) DUE TO DUE TO	ency days
Conditions, if eny, which (b)	
gave rise to immediate cause	
(a), stating the underlying DUETO	
cause last. (c)	T SOLUTION TO THE TOUR AND THE SOLUTION OF THE
Chronic brain syndrome with senile brai	n disease without qualifying Performed? Yes \(\sigma \) NO \(\sigma \)
200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED OR CONTRIBUTING CAUSE OF DEATH UNITED CAUSE OF DEATH	. (Enter neture of injury in Pert I or Part II of item 18.)
	CE OF INJURY (Home, farm, † 20f. (City or town) (County) (Stete)
Hour a.m. p.m. 19 at work at work	ory, street, office bidg., etc.)
21. I certify that X) (this hospital) attended the deceased from	8/12/ 1961 1961 2/27/ 19.62, that (We) last
	death occured at 12:30, from the causes and on the date stated above.
saw the deceased live on	22b. DATE
then had been	ATTENDING MED. STAFF
Mace of Freyntimos	
NAME (Type) Naci N. Buyukunsal, M.D.	opingiterd boate nospital
	Sykesville, Maryland
23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY (REMOVAL (Specify)	D
Burial 3-3-1962 Moreland mem	orial Cemetery Baltimote Md.
P	- 100
Zassahn Funeral Home 7401 Belan R	one DATEM 5 162 Cultury S. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY	Carroll		MARYLAND	- CTATE	PENCE (Where decearry)	sed lived, If b. COU		danca befora	edmission)
b. CITY OR TOWN (if	foutside corporate limit give nearest town)	\$,	c. LENGTH OF STAY IN 16	c. CITY OR TOV	VN (If outside corporat	e limits, writ	a RURAL and gi	iva nearast to	wn)
RuralSykes			26y. lm. 26d.	Baltimo	101-	1			
d. NAME OF HOSPIT	AL OR INSTITUTION (f not in hos	pital, give street address)	d. STREET ADDR				e. IS	RESIDENCE
Springfield	State Hosp	ital		731 Rese	rvoir Stre	et			NO K
3. NAME OF DECEASED	First		Middle	Last	4. DATE OF	Mont	h D	ay Ya	ar
(Type or print)	Emma		hardson	Byrn	DEATH	2		7 19	62
5. SEX	6. COLOR OR RACE	7. MARRIE	D NEVER MARRIED	B. DATE OF BIRTH			IF UNDER 1 YEA		R 24 HRS.
female	white	WIDOWE	the same of the sa	1/17/74	la	st birthday) 88 yrs.	Months Day	s Hours	Min.
10a. USUAL OCCUPATI done during most of wor housewife	ON (Give kind of work rking life, even if retire	d) 10b. K	IND OF BUSINESS OR INDUST		County & Stata, or fore	ign country	USA	OF WHAT	COUNTRY?
13. FATHER'S NAME				Marylan			USA		_
John Richa	ndson				DEIA IAWWE				
15. WAS DECEASED EVE		crea las	COCIAL CECUDIAN NO LAW	Duhamel					
(Yes, no, or unkown) (If		rvice)	SOCIAL SECURITY NO. 17.			Addres			
no			nknown Spi	ingfield H	ospital re	cords	- Sykes		
			ine for (a), (b), and (c).]					ONSET AND	
	MAS CAUSED BY:	Cer	ebral vaxcular	accident					days
32	1 X DUE TO								
Conditions, if any	which (b)								
geve rise to immedia	ate cause								
(a), stating the un	derlying								
_	SIGNIFICANT CONDIT	IONS CON	TRIBUTING TO DEATH BUT N	OT RELATED TO THE TE	PMINAL DISEASE CON	NOITION GIV	/FN IN PART 1/a	11 10 WAS	ALITOPSY
오		-	anoid state.	OF KLEATED TO THE TE	KMMAL DISLASE COI	ADITION GI	A FIR HA LAKE IVE		ORMED?
OR CONTRIBUTING	AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OCCURE	D. (Enter nature of injury	y in Pert I or Pert It of	item 18.)			
20c. TIME OF INJUI	RY Month, Day, Yaa	While	Not While fac	ACE OF INJURY (Home, story, street, office bldg.	farm, 20f. (City or , atc.)	town)	(County)		(Stata)
- Print	19	at wor		30/27	1	- /-	-/-		
21. I certify the	nat () (this hospited alive on	al) attended 2/71	ded the deceased from			2/.7 ne causes	and on the	, that CX date state	(we) last
22a. SIGNATURE	hos:	h.	Bik	ATTENDING PHS.	MED. DIRECTOR	STAFF PHYS.		22	b. DATE SIGNED
22c. PHYSICIAN'S NAME (Typa)	Naci N.	Buyuk	unsal, M. D.	2d_ADDRESS	Springfie Sykesville	ld Sta	te Hosp	ital	
23a. BURIAL, CREMATIC	ON, 23b. DATE THER	EOF	23c. NAME OF CEMETERY	OR CREMATORY	23d. LOCATIO			(Stala)
REMOVAL (Specify)	2-10-6	2	Druid Ri	dge			le. Md		
24 FUNERAL DIRECTOR	'S SIGNATURE		ADDRESS		REC'D BY REGISTRA	R 25b. RE			
John O. M	itchell &	Son	s, Inc.	DATI			CINCLUM A.	/ Change	
	aw Place								

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ISTICAL RESEARCH AND RECORDS. 301 W. PRESTON STREET. BALTIMORE 1, MARYLAND funeral should 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution; Residence before edmission) a. COUNTY b. COUNTY 4 pg MARYLAND Carroll Marvland City b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL end give neerest town) write RURAL end give nearest town) Baltimore 31 Sykesville 8mos.29dvs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? 1921 E. Fayette St. YES NO X Springfield State Hospital complete Middle 4. DATE Month Yeer DECEASED DEATH February (Type or print) Howard Clark 19 62 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR) IF UNDER 24 HRS. last birthday) and Months Devs Male White Hours WIDOWED DIVORCED X April 14. 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) U.S.A. None Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Then please 2. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (Ifyes give war or dates of service) No Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease. Years. IMMEDIATE CAUSE (a) DUE TO Conditions, if eny, which (b) geve rise to immediate cause DUE TO (e), steting the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION Moderately advanced - - Pulmonary tuberculosis PERFORMED? C.B.S. assoc. with circulatory Disturbance with psychotic reaction. NO X 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Pert I or Pert II of item 18.) MEDICAL 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, farm, (Stete) Month, Dev. Year 20d. INJURY OCCURRED 20f. (City or town) (County) Not While factory, street, office bldg., etc.) While Hour e.m. at work et work 21. I certify that (I) (this hospital) attended the deceased from 5-10- 19 61 to 2-9- 19 62 that (I) (we) last saw the deceased alive on. 2-9-1962, and that death occurred aff. 15M, and the causes and on the date stated above. 22e. SIGNATUR ATTENDING SIGNED PHYS. DIRECTOR PHYS. M.D. 22c. PHISICIAN'S 22d. ADDRESS NAME (Type Agustin del Campo. Springfield State Hospital, Sykesville, Md. filed v 23e. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY à di TO 256. REGISTRAR'S 24 EUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR VR A15 (4) Chritun X. 15M 7/61

ithin 24 hours after

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 01730 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) a. COUNTY b. COUNTY by the and 2 death. Carroll MARYLAND Maryland by th b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL end give neerest town) write RURAL end give nearest town) lyr.5moths 16dvs. Sykesville Baltimore 31 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO Springfield State Hospital Ballon completer 3. NAME OF DECEASED OF (Typa or print) Marie Connie Cull lum DEATH 19 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH IF UNDER 24 HRS. 9. AGE (In years | IF UNDER 1 YEAR and last birthday) Months Devs Hours Min. Female WIDOWED [DIVORCED October 8, 1889 physician 10a. USUAL OCCUPATION (Giva kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Housewife Maryland U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 2 attending and Frank . Deitz Mollie Elizabeth Vogel a Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT removal, (Yas, no, or unkown) | (Ifyesgivawarordetas of servica) attending physician. as been signed by the Springfield Hospital Records 1B. CAUSE OF DEATH |Enter only one cause per line for (e), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Septicemia IMMEDIATE CAUSE (e) Davs has been signification to burial-transit p DUE TO Pulmonary abscess Weeks Conditions, if eny, which gave rise to immediate causa DUE TO (a), steting the underlying Bed sores couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) | 19. WAS AUTOPSY PERFORMED? Late latent syphilis. C.B.S. assoc. with ce Old myocardial infarction, years. CERTIFICAT assoc. with cerebral arterio, with psychotic reaction. NO 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury In Part I or Pert II of item 18.) OR CONTRIBUTING CAUSE OF DEATH MEDICAL (Stete) 20c. TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) factory, street, office bldg., etc.) While Not While Hour e.m. at work af work 21. I certify that (I) (this hospital) attended the deceased from. 9-26- 19.60 to 2-11-22b. DATE 22e. SIGNATURE ATTENDING 2-11-1962 DIRECTOR PHYS. PHYS. M.D. 22d. ADDRESS 22c. PHYSICIAN NAME (TY Agustin del Campo, \$pringfield State Hospital, Sykesville, Md. ector, filed v TO HO death.
TO FUN director, 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) Burial 2-15-62 Holy Redeemer Cemetery 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 1SM 7/61 Chilling S. Thous DATE ER 1 3 '62

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The law requires that the death certificate

RYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1 3 ALL STATES AND AND AND AND AND ADDRESS OF THE PARTY OF TH THE RESERVE OF THE PARTY OF THE THE REPORT OF THE PROPERTY OF THE PARTY OF T

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	W	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18	
2	ation,	01733 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Rog. Dist. No.17	716
should	cremat	PLACE OF DEATH a. COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before add a. STATE MARYLAND A. COUNTY A. COUN	mission)
Page 4	ig M	b. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest ond give nearest lown) C. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown)	own)
netor.	prior to	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street giftiress) d. STREET ADDRESS e. IS	RESIDENCE N A FARM?
neral (gistror	NAME OF First Middle Last 4. DATE Month Day OF OF DECEASED (Type or print) MARCHALL FLATER DEATH FELL 15	Year 19 6 2_
the fu	the re-	THINGHALL COLUMN SAFELA	DER 24 HRS.
and 3 to	d 2 with	Oa. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY OF WHAT COUNTRY III. BIRTHPLACE (State or foreign country)	T COUNTRY?
s 1, 2,	ges 1 and	3. FATHER'S NAME M. AND Heall Phallip Hotel 14. MOTHER'S MAIDEN NAME ROBERTS ROB	1
		5. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Ves. no. or unknown) (If yes, give war or dates of service) 2/7-14-3686 Max	
18. Gi	permit.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transquistion - he have give	WEEN DEATH
in Item		Continue to Due to	
pencil	burial-transit	gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO	
ding" in	os o os o	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAY	S AUTOPSY ORMED?
d pend	å	20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH: 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.)	
the war	e 3 should	20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED While Not while at work at work at work 19 at work 1	(Stote)
iting	Pogo	21. I certify that I took charge of the remains described above, held an Autopsy . Inspection . Inquiry , and	find that
te, wr	CTOR	death resulted from: Natural causes, Accident, Suicide, Undetermined cause	
ifico	DIRECTO	SIGNATURE M.D. CHIEF MEDICAL EXAMINER	12-62
the	FUNERAL L removal.	EXAMINER'S TAMES MARCH DEPUTY MEDICAL EXAMINER DEPUTY DEPUTY MEDICAL EXAMINER DEPUTY DE	LL
cute	0 P P P P P P P P P P P P P P P P P P P	20. BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Shemoval (Specify) 2/8/62 Pleasant Home Cimity Tombsong RD.	md md
'S. A1	THE PROPERTY	3. FUNERAL DIRECTOR'S SIGNATURE ADDRESS - 240. REC'D BY REGISTRAR'S SIGNATURE L. S. MANTEN D. MANTEN D. 15 162 CHANGE & THOMAS	

FOR STATE HEALTH DEPT. irector. Page or your files. Boar TO DEPUT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deplease executed the certificate, writing the word "pending" in pendi in Item 18. Give Pages 1, 2, and 3 to the fund 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State or its designated agent, prior to burial, cremation, or removal, and in any event within 72 tours. VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1734 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived, If Institution: Re	sidence before admission)					
Carroll	a. STATE Maryland b. COUNTY Frederick						
b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and						
write RURAL end give neerest town)		0 × 3					
Sykesville lyr.6mos.2day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	Frederick /	I . IS RESIDENCE					
		ON A FARM?					
Springfield State Hospital 3. NAME OF Middle	None	YES NO X					
DECEASED	OF	Dey Yeer					
AATTTAM U.		18. 1962					
The state of the s	DATE OF BIRTH 9. AGE (In years IF UNDER 1 Y	EAR IF UNDER 24 HRS.					
	Sept. 4, 1883 78 yrs. Months	ays nours min.					
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Y 11. BIRTHPLACE (State or foreign country) 12. CITIZ	EN OF WHAT COUNTRY?					
Various	Maryland	U.S.A.					
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME						
Edwin Freed	Thannie Baker						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. II	NFORMANT Address						
(Yes, no, or unkown) (Ifyesgivewarordetesofservice)	Springfield Hospital Records						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	- pa = 11612020 110002 002 110001 00	INTERVAL BETWEEN					
PART I. DEATH WAS CAUSED BY:		ONSET AND DEATH					
IMMEDIATE CAUSE (a) Heart failure		years					
DUE TO							
Conditions, if any, which gave rise to immediate cause (b) Severe arterioscle	rotic heart disease	years					
(a), stating the underlying DUE TO							
cause last. (c)							
C.B.S. assoc. with cerebral arteriosclere	T RELATED TO THE TERMINAL PISEASE CONDITION GIVEN IN PART 19 DSIS WITH DSVCHOTIC reaction.	(e) 19. WAS AUTOPSY PERFORMED?					
Fracture, head of humerus.		YES INO					
PRIMARY CLOSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (ET	nter nature of Injury in Part I or Pert II of item 18.)						
20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLACE While Not While at work 1 at work 1 hos	CE OF INJURY (Home, farm, ' 20f. (City or town) (County	(State)					
Hour a.m. Feb. 7,9 62 While Not While Hos	spital Sykesville Ca	rroll Md.					
21. I certify that I took charge of the remains described above, hel-	d an Autopsy X. Inspection X. Inquiry X	and in my opinion					
death resulted from: Natural causes 7. Accident . Suicident	de , Homicide , Undetermined manner						
6 01	CHIEF MEDICAL EXAMINER						
ACTUAL CENTRO / MANA	ASSISTANT MEDICAL EXAMINER	DATE SIGNED					
SIGNATURE	QEPUTY MEDICAL EXAMINER						
NAME Hyper James T. Marsh, M.D.	Address (Street, city, town, or county)	2/19/62					
22a. BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR	CREMATORY 22d. LOCATION (City, town, or country)	(State)					
Burial 2-22-62 Mount Olivet	Cemetery Frederick, Maryland						
23. FUNERAL DIRECTOR PLANEL AND SSS	24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGI						
M. R. Etchisch & Son, Frederick, Maryland							
	DATEFER 21 '62 Cities 8, 45	tank					

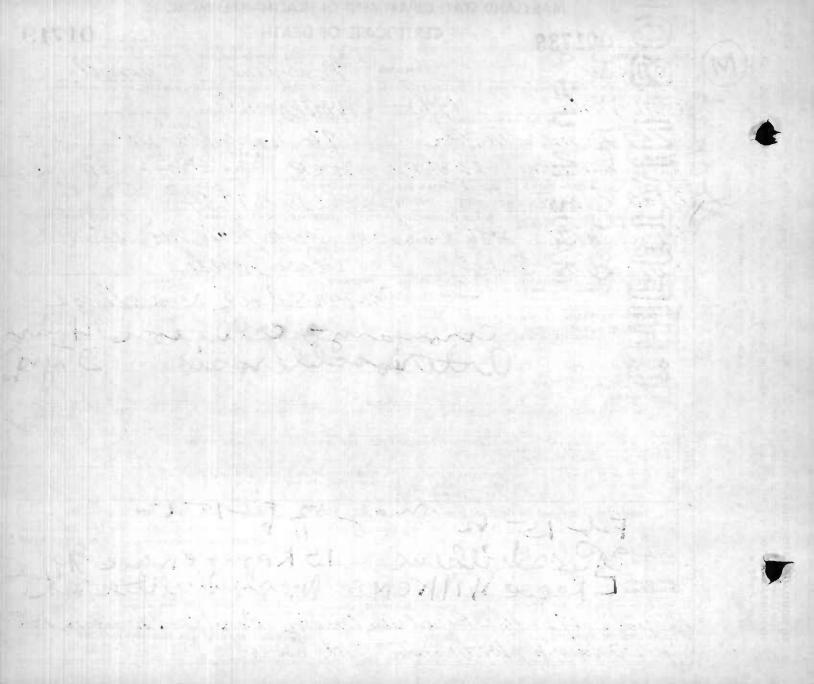
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	1		MARYLAND STATE DEPARTMENT OF HEALTH
		-	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 01718
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rs aft			1. PLACE OF DEATH a. COUNTY a. STATE AA b. COUNTY b. COUNTY
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hin ba	aff	, -	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE
. <u>₹</u>	Surs		DANTIN PORT ON A FARM
uted lete	2 ho		3. NAME OF First / Middle Last, 4. DATE Month Dey Yeer
De de	pal n		(Type or print) FAMILY FILL THE DEATH Feb. 10 1962
6 0	0		5. SEX 6. COLOR OR RACE 1. MARRIED NEVER MARRIED 1 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS
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the atte	E E		15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) (Ifyesgivewarordetesofservice)
that n.	it.		18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]
icia	or r		ONSET AND DEATH
phy	on,		IMMEDIATE CAUSE (a) A Crite ful minastry Branche firetunana. 24 los
WE I	tran		Conditions, if any, which (b)
he li end bee	cre	3	gave rise to immediate cause
r aff	e br	3	(a), stating the underlying CC (c)
IAN o le	t o	0	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPS
SIC	or t		PERFORMED? YES NO
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P rel	P 0		21. I certify that (I) (this hospital) attended the deceased from Sty 29
R V	houl		saw the deceased alive on Felin and that death occurred at It AM, from the causes and on the date stated above
OEE	3 8		220. SIGNATURE POR DELLE DELLE SIGNATURE ATTENDING MED. STAFF 26 16 . 6 2 SIGNI PHYS. PHYS. DIRECTOR PHYS. 7 26 16 . 6 2 SIGNI
-	ith t		72c PHYSICIAN'S 22d ADDRESS 7 L ALL JJ D
SP.	ξ A V D		NAME (Type) Sanc Okutman Syke suille, Mol.
HO FU	file		23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (CAN LOWID or county) (Stote)
ဂ္မခ်င္မ	÷ 2		REMOVAL (Specify) 2-12-62 Struston Park Ballimore, Mil
	15 (4)		24 FUNERAL DIBECTOR'S SIGNATURE ADDRESS 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE
15M	Noi Di	1	Gullo A. Halghe Gryswill, My DATE FER 13'62 andre S. Trous
	de	1 3	

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CERTIFICATE OF DEATH Reg. Dist. NO1719 01736 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) filed a. COUNTY b. COUNTY MARYLAND uneral b. CITY OR TOWN (If outside carparate limits, write pe C. LENGTH OF STAY IN 16 OR TOWN (If autside corporate limits, write RURAL and give negrest town) RURAL and give nearest lowell shauld d. NAME OF HOSPITAL (If nat in haspital give street address) OR INSTITUTION e. IS RESIDENCE ON A FARM? YES NO 14 executed within 24 haurs and 2 NAME OF DATE OF DEATH Middle First Year Day filled DECEASED (Type or print) 196 9. AGE (In years last birthday) SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER 1 YEAR IF UNDER 24 HRS B. DATE OF BIRTH completely Manths Haurs WIDOWED [USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country 12. CITIZEN OF WHAT COUNTRY? dyning mast af warking life, even if fetired) and after a 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address (If yes, give war or dates of service) attending 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise to immediate DUF TO cause (a), stating the underoug lying cause last. burial-transit PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY remayal, PERFORMED? YES NO T 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I ar Port II of item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth. 20f. (City or town) Doy, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, (State) (Caunty) factory, street, affice bldg., etc. Haur a.m. While Nat while at wark at wark Attet I last saw the deceased attended the deceased fram PM, fram the causes and an the date stated above. alive an CTOR: prior 3 shauld PHYSICIAN'S FUNERAL NAME (Type) BURIAL, CREMATION, 22d. LOCATION (City, 4(State) 22c. NAME OF CEMETERY page the 23. FUNERAL DIRECTOR'S SIGNATURE 24b. REGISTRAR'S SIGNATURE arthur S. Krous VS A15 (4) 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



rithin 24 hours after ed in by the funeral Pages 1 and 2 should TO HOSP I OR ATTENDING PHYSICIAN: The law requires that the death certiticate be executed within 24 death. If 4 may be retained by the hospital or attending physician.

TO FUNDAM DIRECTOR: After this certificate has been signed by the attending physician and completed director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after The law requires that the death certificate be executed OR ATTENDING PHYSICIAN: TO HOSP VR A15 (4)

15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01720

- 01	4.3.4					
1. PLACE OF DEATH				CE (Where deceased lived,		nce before admission)
Carroll		MARYLAND	a. STATE Marvla		YTAUC	nv Co.
b. CITY OR TOWN (if outside o	orporate limits,	c. LENGTH OF STAY IN 16		If outside corporate limits, w		
write RURAL and give near		27 days	Combon	Land.	0100	2 - 2
d. NAME OF HOSPITAL OR IN	STITUTION (if not in hos	21 yrs./10 mo	d. STREET ADDRESS		0,100	e. IS RESIDENCE
Springfield			201. 07	enn St.		ON A FARM?
3. NAME OF	First	Middle Middle	Last		onth Day	
DECEASED (Type or print)	11131	WIIGGIA	Lasi	OF		
	Ella	Elizabeth	GORMAN		ruary 4,	1962
5. SEX 6. COLC	R OR RACE 7. MARRIE	D NEVER MARRIED 8	. DATE OF BIRTH	9. AGE (In year last birthda	ers IF UNDER 1 YEAR Y) Months Days	Hours Min.
female whi		D DIVORCED	4=28=1888	73 yrs.	1110111110	
10a. USUAL OCCUPATION (Give done during most of working life,	kind of work 10b. K	IND OF BUSINESS OR INDUSTR	Y 11. BIRTHPLACE (Cour	nty & State, or foreign count	ry) 12. CITIZEN	OF WHAT COUNTRY
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13. FATHER'S NAME			14. MOTHER'S MAIDEN	NAME Maryland	0.00	
Mallaham Mala			Journal att	2		
Milton Hite	ARMED FORCES? 16.	SOCIAL SECURITY NO. 1 17. 1	Harriett Bro	temarkel Add	ress	
(Yes, no, or unkown) (Ifyesgivew	ar or dates of service)			, TT	70	
No No			ringileld St	ate Hospital		TERVAL BETWEEN
18. CAUSE OF DEATH [En		ine for (e), (b), end (c).				SHERVAL BETWEEN
		rdial infarcti	on			day
10.	DUE TO					
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geve rise to immediate cause	DUE TO					
(a), steting the underlying cause lest.	(c)				F 2 74 75 1	
		TRIBUTING TO DEATH BUT NO	T RELATED TO THE TERMI	NAL DISEASE CONDITION	GIVEN IN PART 1(a)	19. WAS AUTOPSY
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20e. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE OF CONTRIBUTING MEDICAL	OF DEATH	CRIBE HOW INJURY OCCURED	. (Enter neture of injury in	Part 1 of Peri II of Hell 15.		
ZOC. TIME OF INJURY MO	nth, Dey, Yeer 20d.	INJURY OCCURRED 20e. PLA	CE OF INJURY (Home, farr	m, (20f. (City or town)	(County)	(State)
20c. TIME OF INJURY Mo	While	Not While fect	ory, street, office bldg., etc			
-	19 et wor		1 - 1 -	0.0.44		
		ded the deceased from				
saw the deceased alive	on 2/4/62	19, and that	geath occured at.1	OM, from the cause	as and on the o	date stated above
22e. SIGNATURE	() (6)	, (ATTENDING_	MED. STAFF		22b. DATE SIGNED
MADI	A. Du	unkenso M		DIRECTOR PHYS.		2-11-62
22c. PHYSICIAN'S	00	1	22d. ADDRESS			
NAME (Type) Nac	i N. Buyuku	nsal, M.D.	Sykesvi	lle, Maryland	d	
23a. BURIAL, CREMATION, 23b.	DATE THEREOF	23c. NAME OF CEMETERY		23d. LOCATION (City,		(State)
REMOVAL (Specify) Burial Fe	eb 7- 1962	Poschill Com	+ 0 777	Cumberland	Maryla	nd
24 FUNERAL DIRECTOR'S SIGNA		Rosehill Ceme	. 25a, REG	C'D BY REGISTRAR 25b.		
Ruth E. Silcon		710/1 Decatur S	treet aryland DATE	FER 7 '62	Cirilian &	
Radii E. Dileoz		ominer Tand L	ar J Tarra DAIR		A. 1	UNAMES

1157 113 THE REPORT OF THE PARTY OF THE And the state of t

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) a. CAUNTABET. b. COUNTY Baltimore city Maryland by the and 2 death MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c, CITY OR TOWN (If outside corporate limits, write RURAL end give neerest town) lvear 7mo 6da. Baltimore d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) IS RESIDENCE ON A FARM? Springfield State Hospital 1230 E. Belvedere Ave. YES NO complete NAME OF Middle Month Day 1962 George Leonard Hebble Feb. (Type or print) Male 6. COLOR OR RACE 7. MARRIED TO NEVER MARRIED 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. B. DATE OF BIRTH last birthday) Motoths | Boys White WIDOWED 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Baltimore, Maryland Unknown U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME PHYSICIAN: The rather than the hospital or attending physician.

The hospital or attending physician.

The hospital or attending the attending the hospital or attending the h George Hebble Christine Wittig 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT removal, (Yes, nay or unkown) | (Ifyesgive wer or dates of service) Springfield State Hospital Record Sykesvelle 1B. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Inanition due to old age IMMEDIATE CAUSE (a) DUE TO Conditions, if eny, gave rise to immediate cause DUE TO the bur burial, A.S.C.V.D. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY C.B.S. Associated with cerbral Arteriosclerosis with Psychotic reaction yes 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Part I or Pert II of item 18.) 20e. ACCIDENT WAS UNDERLYING OF CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, 1 20f. (City or town) (County) (State) Month, Dey, Yeer factory, street, office bldg., etc.) While Not While Hour e.m. may be retaine DIRECTOR: at work n.m. 21. I certify that (I) (this hospital) attended the deceased from 6-11-60, 19....., to 2-6-62, 19....., that (I) (we) last 22b. DATE ATTENDING Y SIGNED DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSI NAME (Type) Agustin del Campo Springfield State Hospital 23d. LOCATION (City, town or county) 23c, NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION, | 23b. DATE THEREOF REMOVAL (Specify) OF FAITH ARDENS BURIAL 24 FUNERAL DIRECTOR'S SIGNATURE 250, REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE VR A15 (4) arling S. Thouse

ARYLAND STATE DEPARTMENT OF HEALTH

after deoth. Page 4 ATTENDING PHYSICIAN: The tow requires that the death certificate be executed within 24 TO HOSPITAL TO FUNERA

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND

01720	CERTIFICA	TE OF DEATH		01722
1. PLACE OF DEATH a. COUNTY Carro //	MARYLAND	2. USUAL RESIDENCE (When a. STATE	re deceased lived. If institution: b. COUNTY	Residence before admission) Auroll
MANChester ML	LENGTH OF STAY IN 16	X MAnch	es tu /11	1
d. NAME OF HÖSPITAL (If nat in haspital, give street add OR INSTITUTION	dress)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES NO D
3. NAME OF DECEASED (Type or print) HEINDEL,	ANN	Lucy	OF DEATH FEBRUARY	Day Year 7 1962
F W WIDOWED		B. DATE OF BIRTH	last birthday) M	UNDER 1 YEAR IF UNDER 24 HR lanths Days Haurs Min.
10a. USUAL OCCUPATION (Give kind af wark dane during most af warking life, even if retired) House Registry	ND OF BUSINESS OR INDU	York Co.	Co.	12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME Releases 74. 746		14. MOTHER'S MAIDEN NA	me E. Dech	C)
1S. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		Kurrell Hera	Address Mana	lector, mo
18. CAUSE OF DEATH [Enter only one cause per line of PART I. DEATH WAS CAUSED BY: MMEDIATE CAUSE (a)	far (a), (b), and (c).	Myocar	detici	INTERVAL BETWEEN ONSET AND DEATH
Canditians, if any, which gave rise to immediate cause (a), stating the under-lying cause last.	pertensine	Cardio Vas	cular Dise	are
PART II. OTHER SIGNIFICANT CONDITIONS CON	NTRIBUTING TO DEATH BUT	T NOT RELATED TO THE TERMIN	al disease condition given	IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO
OR CONTRIBUTING EL CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	BE HOW INJURY OCCURRE	ED. (Enter nature of injury in Po	art I ar Part II af item 1B.)	
Haur a. m. While		LACE OF INJURY (Hame, farm, actary, street, affice bldg., etc.)	20f. (City ar tawn)	(Caunty) (State
21. I certify that (I) (this haspital) attended saw the deceased alive an Janu 2				, 1962 that (I) (we) la
220. SIGNATURE BU	sh-		STAFF ECTOR PHYS.	22b. DATE 2-7-62 SIGNE
26. PHYSICIAN'S NAME (Type) Joseph E. E.	Bush	22d. ADDRESS	+ ZAD M	Jaryland

23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 10 196%

24. FUNERAL DIRECTOR'S SIGNATURE

23d. LOCATION (City, town, or county)

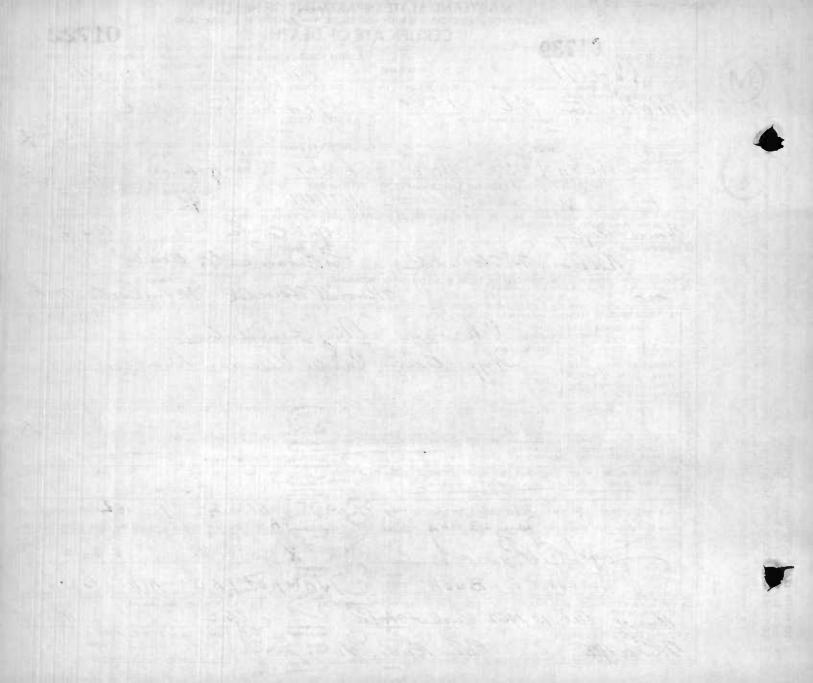
2Sb. REGISTRAR'S SIGNATURE

(State)

Shew Rock, Po

25a. REC'D BY REGISTRAR DATE EN 1 3 '62

Chillen S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Park may be retained by the hospital or attending physician.

TO FUNER B DIRECTOR: After this certificate has been signed by the attending physician and completely with by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Fages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 7/61

	MARYLAND	STATE DEP	ARTMENT	OF HEA
BRUIGIAN AT CHARLES				

LTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CEPTIFICATE OF DEATH 01723 11741

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived, if institutions Res	idence before admission)
Carroll MARYLAND	Maryland b. COUNTY Baltin	ore /
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and g	
Sykesville 15 days	Towson 4 03	x -2.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS	e. IS RESIDENCE
Springfield State Hospital	8208 Loch Raven Blvd.	YES NO
3. NAME OF First Middle DECEASED	Last 4. DATE Month	Day Year
(Type or print) Margaret Kauper	Helgert DEATH February	5, 19 62
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8	DATE OF BIRTH 9. AGE (In years IF UNDER 1 YE last birthday)	
Female White WIDOWED TO DIVORCED NO	ovember 16, 1889 72 yrs. Months Da	ys Hours Min.
		N OF WHAT COUNTRY?
Housewife	Commons	C A
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	S.A
George Kauper	Margaret Norndorfer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. I	NFORMANT Address	
(Yes, no, or unkown) (If yes give war or dates of service)		
NO	Springfield State Hospital Reco	interval Between
DART I DEATH WAS CAUSED BY		ONSET AND DEATH
IMMEDIATE CAUSE (a) Arteriosclerotic h	eart disease.	Years
DUE TO		
Conditions, if any, which \ (b) Diabetes Mellitus		Years
gava rise to immediate cause		
(a), stating the underlying DUE IO		
(c)	T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I	a) 10 WAS ALITOPSY
E		PERFORMED?
C.B.S. assoc. with senile brain disease	with psychotic reaction.	YES NO X
(IF EITHER, NOTIFY MEDICAL EXAMINER)	, (Enter nature of ໂກງພຣັ້ງ in Part I or Part II of item 18.)	
	CE OF INJURY (Home, farm, 20f. (City or town) (County ory, street, office bldg., etc.)	(State)
21. I certify that (I) (this hospital) attended the deceased from	1-20- 1962 to 2-5- 1963	that (I) (we) last
saw the deceased alive on		
22e. SIGNATURE	death occured at.C.RAPA, from the causes and on the	22b. DATE
Constant lel Handon	ATTENDING MED. STAFF PHYS. DIRECTOR PHYS.	2-5-62
22K. PHYSIGIAN'S	22d. ADDRESS	~ , 00
NAME (Type) Agustin del Campo, V.D.	\$pringfield state Hospital, Syl	cesville, Md
23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY	OR CREMATORY 23d. LOCATION (City, town or county)	(State)
BURIAL FEB 9 1962 BALTIMOI	RE CEM. NORTH AUE & GAY	ST MD
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIC	
DIPPEL BROS 7110 BELAIR A		
MILLE DIO 1110 BELAIR A	OAD DATE 1 62 Cirching &	Though

The state of the s Lighten to all with your rite . which be and the light that the course will be A STATE OF THE PARTY OF THE PAR THE PROPERTY OF SECTION AS A SECOND OF THE PARTY OF THE P The first was a second of the state of the second of the s

I and 2 should within 24 hours after DHOSPILY OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with death. Page may be retained by the hospital or attending physician.

OFUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page effect with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours. death. Page 15 TO FUNERA. TO HOSPIT

15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 01724 01724

NAME OF PRINT Middle STATE OF NAME OF NAME NAME OF	- 1-				
Carroll Carr					on: Residence before edmission)
b. CITY OR TOWN: (If outside compones limits, write SURAL end give nessed lows) Teneytown Teney					armoll
TABLETTOWN d. NAME OF HOSPITAL OR INSTITUTION (if not in beginlist, sive styce) address) d. STREET ADDRESS IN AMERIC OF First Middle Last Frederick Street No. ALE AND ATTE Frederick Street No. ALE AND	-	b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 1b			
SAME OF PROCESSED First Middle Last DATE Month Dey Yest No. Processed		write RURAL end give nearest town)	Y		
S. NAME OF Frederick Street Frederick Street Strip No. ON ARE Proceedings Proceding Pr	-	Taneytown	Taneytown		1 - 15 DESIDENCE
3. NAME OF PROBLEMS (Type or print) PIUS Lee Hemler DEATH February 15, 1962 S. SEX O. COLOR OR RACE MARRIED NEVER MARRIED S. DATE OF BIRTH DATE OF BIRTH S. DATE OF BIRTH DATE OF BIRTH			d. SIKEET ADDRESS		ON A FARM?
DECERSED (Type or print) Pius Leo Hemler DEATH February 15, 1966 S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH Male White Whowed M 5. DATE OF BIRTH Who were Married 9. Add (is years) 16. WINDER 184AR IF UNDER 184 184	_	XXXX Frederick Street	Frederick Kook S	treet	YES NO
S. SEX 6. COLOR OR RACE 7. MARKED NEVER MARKED NONCECED JUNE 13, 1881 9. CO. SECURITY 19. MARKED NONCECED JUNE 13, 1881 9. O. ACE (Ing. very in Funder) 19. Marked				E Month	Dey Yeer
Sex 6. COLOR OR RACE MARRIED NEVER MARRIED 9. DATE OF BIRTH 9. AGE (lie yees) FOUNDER! TEAR IF UNDER 24 But binding Months Days Days Months Days Months Days Days Months Days Days Days Months Days Days Days Months Days Days Days Days Days Months Days Da		/T	Hemler DEA	TH February	15. 19 62
Male White Widowed Divorced June 13, 1881 80 yr. Months Days Hours Mary Months No Months Days Months Days Months Mary Months Days Months Mary Months Days Mo	-	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8.		9. AGE (In years IF UND	ER 1 YEAR IF UNDER 24 HRS.
10. SUNA OCCUPATION (Give bind of work done during most of working life, even if refired) Retired Clerk 13. FATHER'S NAME IOUIS J. Hemler 13. WAS DECASED EVER IN U.S. ARABE FORCES? (Ves. no. or unknown) (Ifyes) wear of descriptions of the involvement of the i			72 7607		s Deys Hours Min.
Retail Hardware Maryland U.S.A.	-	IN ALSUAL OCCUPATION (Give kind of work 100 KIND OF BUSINESS OF INDUSTR			CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DICEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Address Address No. 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (b) Generally of Pourioritis Immediate cause (a), steining the underlying Conditions, if early white Generally of Conditions, if early white Generally of Conditions PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTOFERD OR CONTRIBUTING CAUSE OF DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTOFERD OR CONTRIBUTING CAUSE OF DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTOFERD OR CONTRIBUTING CAUSE OF DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTOFERD OR CONTRIBUTING CAUSE OF DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTOFERD OR CONTRIBUTING CAUSE OF DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTOFERD OR CONTRIBUTION GAUSE OF DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTOFERD OR CONTRIBUTION GAUSE OF DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTOFERD OR CONTRIBUTION GAUSE OF DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTOFERD OR CONTRIBUTION GAUSE OF DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTOFERD OR CONTRIBUTION GAUSE OR CONTRIBUTI		done during most of working life, even if retired)	II. DIKITIFEACE (COUNTY & STORE	, or lovely it country,	THE THE PARTY OF T
Louis J. Hemler Katherine Goulden	-				U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 16. SOCIAL SECURITY NO. 17. INFORMANT Address 18. CAUSE OF DEATH [Enter only one ceuse per line for (e), (b), end (c).] PART I. DEATH WAS CAUSE (e) Generally of Poulfornitis PART II. DEATH WAS CAUSE (e) Generally of Conditions, if envy, which gove rise to immediate cause (a), stelling the underlying ceuse list. DUE TO Generally of the Terminal DISEASE CONDITION GIVEN IN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTO PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTO PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTO PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTO PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTO PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTO PART III. 19. WAS AUTO PART		I3. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
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18. CAUSE OF DEATH [Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH [Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH [Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH [Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH [Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (c), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (c), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (c), end (c).] 19. CAUSE OF DEATH (Enter only one course per line for (e), (c), end (c).] 19. CAUSE OF DEATH (Enter only one course) -	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. I			
18. CAUSE OF DEATH (Enter only one course per line for (e), (b), end (c).] PART I. DEATH WAS CAUSED BY. DUE TO Conditions, if eny, which give rise to immediate cause (a), steling the underlying ceuse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTO PERFORM YES NO OR CONTRIBUTING CAUSE OF DEATH UNDERSTAND UNDERSTAND DEATH UNDERSTAND			Tomas D. Hamilan	M	Manual and
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RYLAND STATE DEPARTMENT OF HEALTH

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IF UNDER 24 HRS.

Hours

INTERVAL BETWEEN ONSET AND DEATH

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22b. DATE

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ed in by the funeral Pages 1 and 2 should within 24 hours after TO HOSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 death.

S death.

S TO FUNEXAL DIRECTOR: After this certificate has been signed by the attending physician and complet director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after

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MEDICAL CERTIFICATION

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MARYLAND STATE D DIVISION OF STATISTICAL RESEARCH AND RECORD	DEPARTMENT OF HEALTH DS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
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PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission)
county Canall Co. Maryland	a. STATE MO b. COUNTY
b. CITY OR TOWN (if outside corporate limits, write RURAL end give nearest town)	c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town)
St por. lle	Balto 3111-4
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address)	d. STREET ADDRESS o. IS RESIDENCE ON A FARM?
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NAME OF First Middle	Last 4. DATE Month Dey Yeer
(Type or print) - ACAB HARRY T	PM/1 N DEATH 2 - 12 - 19 62
SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B	DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.
M WIDOWED DIVORCED	10-1-1885 lest birthday) Months Deys Hours Min.
. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTR	
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FATHER'S NAME	14, MOTHER'S MAIDEN NAME
	6 0 1
Was deceased ever in U.S. Armed Forces? 16. Social Security No. 17. I	Elez howe
WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. Is, no, or unknown) (Ifyesgivewerordefesofservice)	INFORMANT Address
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saw the deceased alive on 12 Feb 1967, and that	death occured d
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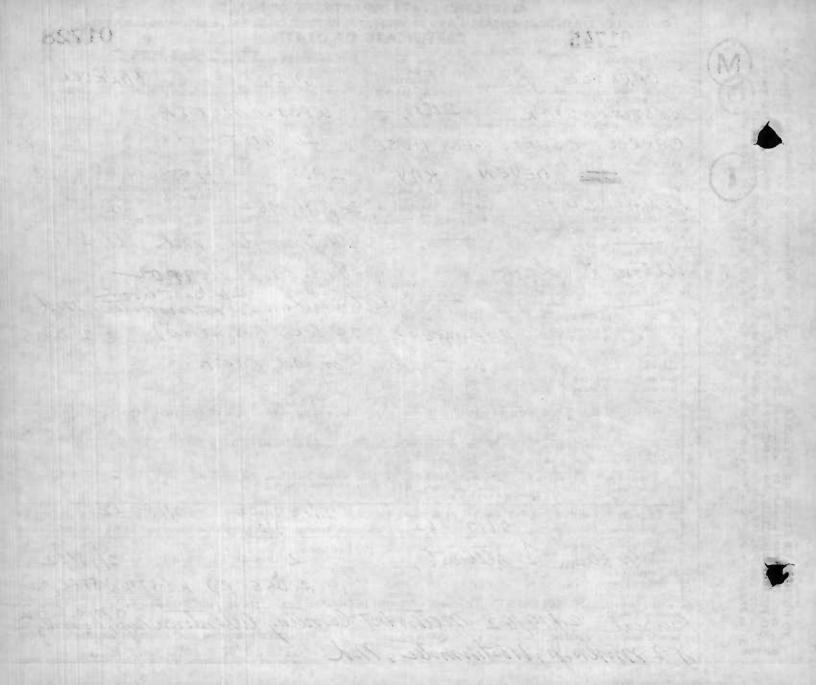
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ificate be executed v	ician and completelinove carbon papers.	aveill, William / 4 mou
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TO HOSPIT	diector, page director, page directo	IIIM DellI eq

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PLACE OF DEAT	Н			2. USUAL RESIDEN	ICE (Where daceass	b. COUNTY	Residence before e	imission)
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b. CITY OR TOWN	(if outside corporete lim	nits,	c. LENGTH OF STAY IN 1			limits, write RURAL as)
	id give nearest town)		Lyrs.10mos.8				114.7	
Sykes		/it not in hou	spital, give street address)	d. STREET ADDRESS	sville		e. IS RES	IDENCE
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3. NAME OF DECEASED	Firs	i -	Middle	Last	4. DATE	Month	Day Yeer	
(Type or print)	Bert	he	Rahy	Vacatio	DEATH	February	77. 19	62
5. SEX	6. COLOR OR RACE	7. MARRIE	D X NEVER MARRIED	Keadle 8. DATE OF BIRTH	9. AG	E (In yeers IF UNDER		The same of the sa
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done during most of w	orking life, evan if retire	ed)	IND OF BUSINESS OK INDU:	STRY 11. BIRTHPLACE (Cou	TOWN WAS	h Co	IIZEN OF WHAT CO	JUNIKT
Housew	ife		-	Marylan			U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN				
Danis	nda Obadasa			777 A A				
15. WAS DECEASED F	VER IN U.S. ARMED FO	RCES? 16	SOCIAL SECURITY NO. 17	Emma Antl	ony	Address		
(Yes, no, or unkown)	(If yes give wer or detes of	service)		,		71001000		
No	_			Springfield He	ospital Re	cords		
		e cause per l	line for (e), (b), end (c).]	1 0			ONSET AND D	
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Cause lest. PART II. OTH C.B.S. (2) 20a. ACCIDENT NOR CONTRIBUTINI, (IF EITHER, NOTIF 20c. TIME OF INJ. Hour e.m. p.m. 21. I certify	ASSOCIATED WAS UNDERLYING G CAUSE OF DEATH Y MEDICAL EXAMINER; URY Month, Day, You 19 that (I) (this hosp	20b. DES	INJURY OCCURRED 20e, 1 Not While at work deed the deceased from	PLACE OF INJURY (Home, fer fectory, street, office bldg., el. m	Pert I or Pert II of it m. 20f. (City or to c.) 195.7, to F.C. 208.P.Mrom the	own) (Co Oruaryll 19 e causes and on	unty) (262 that (1) (v the date stated	Stete) we) las
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PART II. OTH C.B.S. 20a. ACCIDENT OR CONTRIBUTION (IF EITHER, NOTIF 20c. TIME OF IN. Hour e.m. p.m. 21. I certify saw the decer 22e. SIGNATURE	ASSOCIATED WAS UNDERLYING G CAUSE OF DEATH Y MEDICAL EXAMINER URY Month, Day, You that (I) (this hosp ased alive on	20b. DES	INJURY OCCURRED 20e, 1 Not While at work deed the deceased from	PLACE OF INJURY (Home, fer fectory, street, office bldg., etc., and the death occurred and attending.	m, 20f. (City or to F.C.) 195.7., to F.C.) 196. MED. S	own) (Co	unty) (2.62 that (1) (v the date stated	Stete) we) las
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Cause lest. PART II. OTH C.B.S. 20a. ACCIDENT OR CONTRIBUTION (IF EITHER, NOTIF 20c. TIME OF IN. Hour e.m. p.m. 21. I certify saw the decer 22e. SIGNATURE 22c. PHYSICIAN NAME (Typ 23a. BURIAL, CREMA REMOVAL (Specif BURIAL)	Associated WAS UNDERLYING G CAUSE OF DEATH Y MEDICAL EXAMINER; URY Month, Day, You that (I) (this hosp ased alive on	20b. DES eer 20d. While et woi	INJURY OCCURRED 200. INJURY OC	PLACE OF INJURY (Home, fer fectory, street, office bidg., elemants) m	Pert I or Pert II of it m, 20f. (City or to 1) 1957., to Fel 206. (City or to 1) 206. (City or to 1) 207. (City or to 1) 208. (Cit	own) (Co oruarylls causes and on TAFF HYS. X Hospital, N (City, town or coun town Was)	unty) 2.62 that (1) (very the date stated 22b. 2/12/6 Sykesvill (State) (State) (State) (State) (State)	stete) ve) las above DATE SIGNED
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MARYLAND STATE DEPARTMENT OF HEALTH

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ST 21	A	1117-1	RYLAND STATE DEF	ARTMENT OF H	EALTH	
		01745	CERTIFICATE		REET, BALTIMORE	01728
		LACE OF DEATH		2. USUAL RESIDENCE (Where decessed lived, If insti	tution: Rasidance before admission)
	_	CARROLL CO. CITY OR TOWN (if outside corporeta limits,	maryland c. LENGTH OF STAY IN 1b	MP.	tside corporete limits, write RU	DITERUCE PAL and give nearest lown
î		write RURAL end giva nearast town)	2 days	0.00		KAL and diva heatest lown)
2		UESTMINSTER I. NAME OF HOSPITAL OR INSTITUTION (if not in	n hospitel, give street a dress)	d. STREET ADDRESS	INSTER	a. IS RESIDENCE
		CARROLL COUNTY	GEN. ItOSP	26 61	ST. RD	ON A FARM?
	3.	NAME OF First	Middle	Last / 4.	DATE Month	Dey Yaer
		Typa or print) DEVE	1177	LAW	DEATH FEBRUA	ey 18 1962
l	5.	(-CC /. M)	THEFT MARKIED	DATE OF BIRTH	9. AGE (In years IF to last birthday)	JNDER 1 YEAR IF UNDER 24 HRS.
	100	27 17 2	OWED DIVORCED DIVORDIVORDE DIVORCED DIVORCED DIVORCED DIVORCED DIVORCED DIVORCED DIV	FES. 16, 196	State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	do	a during most of working life, even if ratired)		11. BIRTHERE (COUNTY &	722/	11.5.0
	13.	FATHER'S NAME		14. MOTHER'S MAIDEN NAM	AE / ///	4.24.
		alten D. Law		Viranes	: Honor	1_
		WAS DECEASED EVER IN U.S. ARMED FORCES? , no, or unkown) (Ifyasgivawarordatesofsarvica)	16. SOCIAL SECURITY NO. 17.	NFORMANT	21 Ly Abdress	2_1
	110	(ilyasgivawaioi dalasoisaivica)	- a	ton D. Law	LANGE TORREST	ista mol.
		18. CAUSE OF DEATH (Enter only one causa PART I. DEATH WAS CAUSED BY:		12011145 6	(000-1)	INTERVAL BETWEEN ONSET AND DEATH
		IMMEDIATE CAUSE (a)	REMATURE (19 WKS 0	ESTATION	2 0445
		DUE TO	WOT 1/bsd	5m ATI	BIETH	
		Conditions, if any, which (b) gave rise to immediate cause	0001 11034	200 11 10		
		(e), steting the underlying DUE TO				
	Z	PART II. OTHER SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BUT NO	T RELATED TO THE TERMINAL	DISEASE CONDITION GIVEN	IN PART 1(e) 19. WAS AUTOPSY
	ATION					YES NO
	CERTIFIC	20a. ACCIDENT WAS UNDERLYING 20b.	DESCRIBE HOW INJURY OCCURED	. (Enter netura of injury in Part	or Pert II of item 1B.)	
۱		(IF EITHER, NOTIFY MEDICAL EXAMINER)				
	MEDICAL	Hour a.m.	WhileNot While fact	CE OF INJURY (Homa, farm, ory, streat, office bldg., atc.)	20f. (City or town)	(County) (State)
ME		p.m. 17	t work et work	0/11	(= 0/.0	2(2
ı		21. I certify that (1) (this hospital) a	1 1-	700		, 19.2, that (I) (we) las
	7	saw the deceased alive on	177 19.6.2, and that	dearn occured ar	vi, from the causes and	22b. DATE
	18	William I'l	lewait "	.D. PHYS. MED.	CTOR PHYS.	2/18/62 SIGNED
I		22c. PHYSICIAN'S NAME (Typa)		22d. ADDRESS	1 / 6 /	
						TMIN STER, MO,
	230	BURIAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY	OR CREMATORY 2	3d. LOCATION (City, town	or county) (State)
	1	SHARL 12/19/6	2 // Leller dry	Comulally 1	BY REGISTRAR 256. REGIST	Trac's SIGNATURE
	24	5. S. Marles h. lar	atomothe ?	PAL DATEEB 2		1 S. Kraus
6	4	- Hickory to	- monitor , 1.	DAR OLD SA	CARAMO .	I A. I VAMA



OF STATISTICAL RESEARCH AND RECORDS. W. PRESTON STREET, BALTIMORE 1, MARYLAND 01746 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution; Residence before edmission) e. COUNT. hours b. COUNTY MARYLAND OWN (if outside corporete limits, c. LENGTH OF STAY IN 16 c. CITY OPTOWN outside corporate limits, write RURAL end give neerest town) INSTITUTION (if not in hospitel, hive staret eddress) e. IS RESIDENCE ON A FARM? YES NO efely NAME OF DATE Year DECEASED OF (Type or print) DEATH 5. SE) IF UNDER 24 HRS 6. COLOR OR RACE AGE (In yeers IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED last birthday) Months Hours WIDOWED DIVORCED physician USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? BIRTHPLACE (County & Slete, or foreign country) done during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S 5 0 (Yes, no, or unkown) | (If yes give wer or defes of service) 18. CAUSE OF DEATH Enter only one ceuse per lige for (e), (b), and (c AL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which (b) geve rise to immediate cause DUE TO (e), steting the underlying ceuse lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Part I or Pert II of item 18.) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, ' 20f. (City or town) (County) (Stete) factory, street, office bldg., etc.) While Not While Hour e.m. et work et work 19 p.m. 19-14 21. I certify that (I) (this bospital) attended the deceased from..... that (1) (we) last M. from the causes and on the date stated above. .19 c. and that death occured and deceased alive on. saw OR 22e. **SIGNATURE** 22b. ATTENDING STAFF PHYS. DIRECTOR M.D. 22d. ADDRES AME (Type 23d. LOCATION (City, town or county) CEMETERY OR CREMATOR (Stete) BURIAL, CREMATION, | 23b. 23c. 0 24 FUNERAL DIRECTOR'S SIGNATURE 25e. RECO BY REGISTRAR 256. REGISTRAR'S SIGNATURE VR A15 (4) 15M 9/60 arthur S. Traus

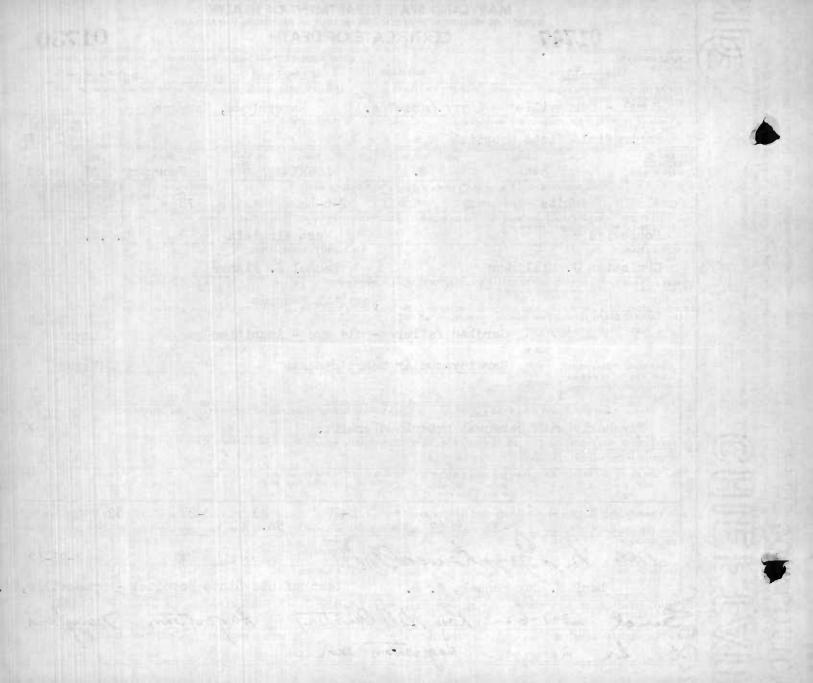
MARYLAND STATE DEPARTMENT OF HEALTH

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DIVISION OF STATISTICAL RESEARCH AND RECORDS --- BALTIMORE 1. MARYLAND 01747 CERTIFICATE OF DEATH with PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY filed b. COUNTY MARYLAND Carroll Maryland Washington uneral b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ond give neorest town)
Rural - Sykesville 1.8vrs.6mos.7da Hagerstown, Marvland d. NAME OF HOSPITAL (If not in hospital, give street address) IS RESIDENCE d. STREET ADDRESS ON A FARM? OR INSTITUTION YES T NO K Springfield State Hospital 2. NAME OF Middle 4. DATE Lost Manth Day filled OF B. LOWRY (Type or print) Eva February 19 62 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 78 yrs. Days Haurs White 2-6-81 Female WIDOWED IX DIVORCED | 12. CITIZEN OF WHAT COUNTRY? 10a, USUAL OCCUPATION (Give kind of work dane 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) during most of warking life, even if retired)
Housewife U.S.A. West Virginia and 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME physician 2. Christian J. Willinger Rachel J. Fisher ave 17 INFORMANT IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO Address No Hospital Records 1B. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) Cardiac failure - old age - inanition Days DUE TO Cardiovascular heart disease Conditions, if ony, which Years gove rise to immediate DUE TO cause (a), stating the underlying cause last urial-tronsit PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? Psychosis with cerebral arteriosclerosis. YES NO M 20a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.) 20e. PLACE OF INJURY (Home, form, 20f. (City or tawn) 20c. TIME OF INJURY Doy, Year 20d. INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) Hour a. m. While Not while ot work at work p. m. 21. I certify that (2) (this haspital) attended the deceased fram. 8-20 19/13 to 2-27 1962 that \$1 (we) last 19 62, and that death accurred at 9AM, from the causes and an the date stated above saw the deceased alive an 00 TENDING MED. DIRECTOR 22c. PHYSICIAN'S 22d. ADDRESS shaul NAME (Type) FUNERAL Springfield State Hospital - Sykesville.Md Buyukunsal. M. D. Naci to 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 0 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATUR 24. FUNERAL DIRECTOR'S SIGNATURE 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

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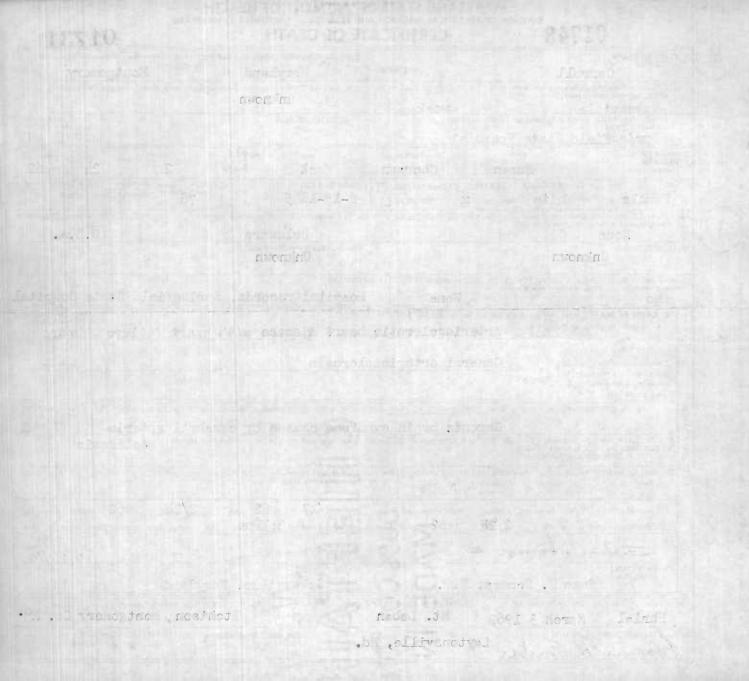
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH 01748

01731

a. COUNTY	arroll		MARYLAND		. STATE	aryla		b. COUNTY		gomer	1
b. CITY OR TOWN (RURAL and give n Sykesyi		ts, write	c. LENGTH OF STAY IN 16	C	c. CITY OR TO	wn (If at		ate limits, write R	URAL and g	give nearest	town)
d. NAME OF HOSPI OR INSTITUTION	TAL (If not in hospital, g				d. STREET AD	DRESS				(RESIDENCE ON A FARM? ES NO
3. NAME OF DECEASED (Type or print)	Fire Su	san	Middle Chorman		Mack		4. DATE OF DEATH	Mar 2	nth	24	Year 1962
5. SEX Female	6. COLOR OR RACE White	7. MARI	RIED NEVER MARRIED DIVORCED DIVORCED		TE OF BIRTH	85	5	AGE (In years last birthday) 70 yrs.	IF UNDER Manths	-	UNDER 24 HRS. aurs Min.
10a. USUAL OCCUPATION during mast af war None	king life, even if retired)	dane 10b.	KIND OF BUSINESS OR INDU	ISTRY		CE (State o	P 1 1 2 2 2 2 2	intry)	12.CITI	ZEN OF WI	A .
13. FATHER'S NAME	Jnknown			14.	MOTHER'S N	IKNOW					S and
	ER IN U. S. ARMED FOR If yes, give war or dates of se		None None	Ho:		reco	rds, S	Add pringfi		tate H	Hospital
gave rise to cause (a), stating lying cause lost. PART II. OT	Canditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic brain syndrome caused by cerebral arterio 20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTION SYNDROME CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part II or Part II of item 18.) scleros									T 1(a) 19. YE	WAS AUTOPSY PERFORMED?
20c. TIME OF INJUI Haur a. m. p. m. 21 I certify the saw the decea	at (I) (this haspital	While at war	Nat while for at wark the deceased from.	actary,	of INJURY (Ho street, affice to 2/17 accurred	bldg., etc.	2ta	2/24	1962		
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type)	Adnan M. So	7	M.D.	M.D.	ATTENDING PHYS. 22d. ADDRES Syk	S	RECTOR L	staff phys.	30	2	22b. DATE SIGNED /2)1/62
	ON 23b DATE THEREC)F	23c. NAME OF CEMETERY C	OR CRE			23d. LOCATI	ON (City, tawn, hison,)		mery	(State) Md.
24. FUNERAL DIRECTOR	R'S SIGNATURE R'S SIGNATURE Barb	n I	aytonsville, M	ld.		25a. REC'D	BY REGISTR	AR 25b. REG	ISTRAR'S SIG		5



ARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 01749 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before edmission) e. COUNTY b. COUNTY Carroll MARYLAND Maryland b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town) write RURAL and give neerast town) - 2 Baltimore #18 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO Y Springfield State Hospital Elkader Rd. 3. NAME OF DATE DECEASED OF (Type or print) DEATH 1962 Norma CAFFERY February 6. COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER 24 HRS. 9. AGE (In years | IF UNDER 1 YEAR last birthday) female WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) U.S.A. Marvland none 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME e attending programme Then please Mary Ellen Jessie McCaffery 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (If yes give wer or dates of service) Springfield State Hospital, Sykesville, Md. 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia davs DUE TO A.S.C.V.D. with compensated heart failure vears geve rise to immediate cause DUE TO (a), stating the underlying PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(+): 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO V C.B.S. assoc. with senility. 200. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW NJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18.) MEDICAL 20e, PLACE OF INJURY (Home, farm, (Slele) 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20f. (City or town) (County) factory, street, office bldg., etc.) While Not While Hour a.m. at work al work 21. | certify that (I) (this hospital) attended the deceased from 6/28/55..... to.....2/21/62..., 19....., that (I) (we) last 22e. SIGNATURE ATTENDING = Inon PHYS. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S Adnan Sonmez. M.D. Sykesville, Marvland 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stete) 23a. BURIAL, CREMATION, 23b. \$0 to REMOVAL (Specify)

VR A15 (4) 1SM 7/61

physician

rick Inc 5305 HARFORD

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Orthung & Thous

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Med in by the funeral Pages 1 and 2 should within 24 hours after TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 death.

34 4 may be retained by the hospital or attending physician.

TO FULL AL DIRECTOR: After this certificate has been signed by the attending physician and compleding the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after

VR A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 01733

01100						
1. PLACE OF DEATH	1	2. USUAL RESIDENCE			nce before edmission)	
a. county Carroll Maryland		a. STATE Maryland b. COUNTY				
b. CITY OR TOWN (if outside corporate limits, c. LEN	GTH OF STAY IN 16	9.7	f outside corporate limits,	write RURAL end give	neerest town)	
write RURAL end give neerest town) Rural—Sykesville	8m. 8d.	Baltimore		311	01-4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give		d. STREET ADDRESS	9		e. IS RESIDENCE	
Enningfield State Meanitel		808 Ct Day	7 Ctmast		ON A FARM?	
Springfield State Hospital 3. NAME OF First	Middle	808 St. Par	Street	Month Dey	Maria	
OF DECEASED (Type or print) Lora	- Middle	McMahon	OF DEATH	2 21	19 62	
5. SEX 6. COLOR OR RACE 7. MARRIED N	EVER MARRIED 8.	DATE OF BIRTH	9. AGE (In y	years IF UNDER 1 YEAR		
Female White WIDOWED	DIVORCED	3/7/75	06	day) Months Days	Hours Min.	
	BUSINESS OR INDUSTR	Y 11. BIRTHPLACE (Coun	ty & State, or foreign cou	entry) 12. CITIZEN (OF WHAT COUNTRY?	
done during most of working life, even if retired) Housewife		Maryland		II	USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN	NAME			
Franklin Weeks		Cramblitt				
	SECURITY NO. 17. I	NFORMANT	Ad	dress		
(Yes, no, or unkown) (If yes give wer or detes of service)		singfield Hea	mital mason	ala Creiran	- Ma	
18. CAUSE OF DEATH [Enter only one cause per line for (ringfield Hos	broar Lecor		ITERVAL BETWEEN	
PART I. DEATH WAS CAUSED BY					NSET AND DEATH	
IMMEDIATE CAUSE (0) MYOCATO	dial infarc	tion			Days	
TAO DUE TO						
Conditions, if any, which (b)						
gave rise to immediate cause DUE TO						
(e), steting the underlying cause lest.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CONTRI	iated with	related to the termin cerebral art	NAL DISEASE CONDITION Cerioscleros	GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMED? YES NO	
		. (Enter neture of injury in I	Pert I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year 20d. INJURY While No at work e.m.		CE OF INJURY (Home, farm ory, street, office bldg., etc.		(County)	(Stete)	
p.m. 19 at work e	ot work					
21. I certify that XX (this hospital), attended th	e deceased from.	6/13/	1960, to 2/	21/ , 1962 ,	that (N) (we) last	
saw the deceased alive on 2/27	19 61 and that	death occured at. 7.	OSA, from the cau	uses and on the c	date stated above	
22e. SIGNATURY	1				22b. DATE	
1 Agos b. The	Dunes		MED. STAFF	DET	2/27/A	
22c. CHYSICIAN'S	mility	22d. ADDRESS	Springfield	State Hos	ni+1	
NAME (Type) Naci N. Buyakunsal	. M.D.				proar	
		OR CREMATORY	Sykesville,		(State)	
REMOVAL (Specify) 2 / 22// 2 9//2	an antr	4 Bound	Bettin	ore me	1	
24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC	'D BY REGISTRAR 256	. REGISTRAR'S SIGNA	ATURE	
- new 11 H Downer F	1/21 8.	2 cf DATE NO	R 1 '62	anima 8. Th	aus	
- 100mm 19 17 11 11 11 11	vers of		(34.1			

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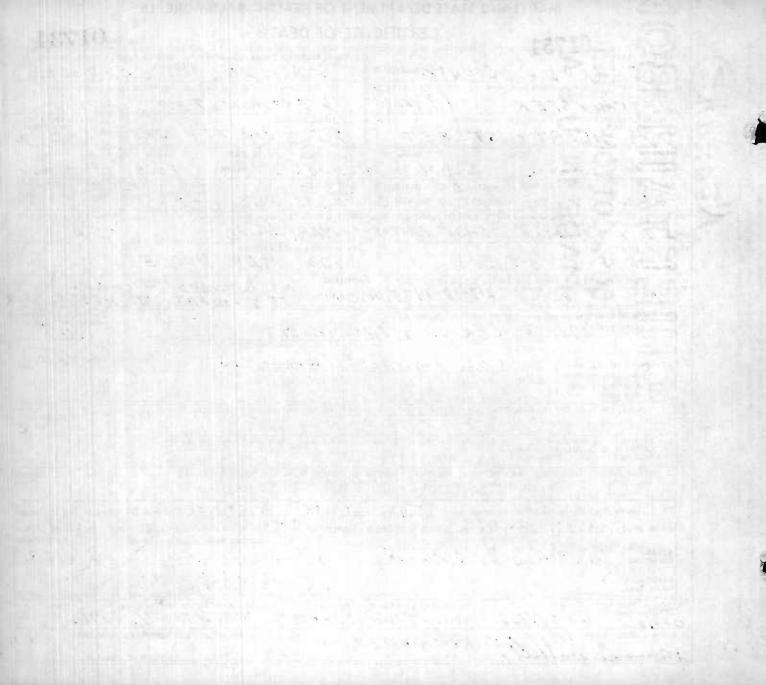
VS A15 (4)

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papers.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after a death. Page may be retained by the hospital or attending physician.

S TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely.

S TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely.

S G director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Ages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event.

MARYLAND STATE DEPARTMENT OF HEALTH

01752 CERTIFICATE OF DEATH 01735 01735

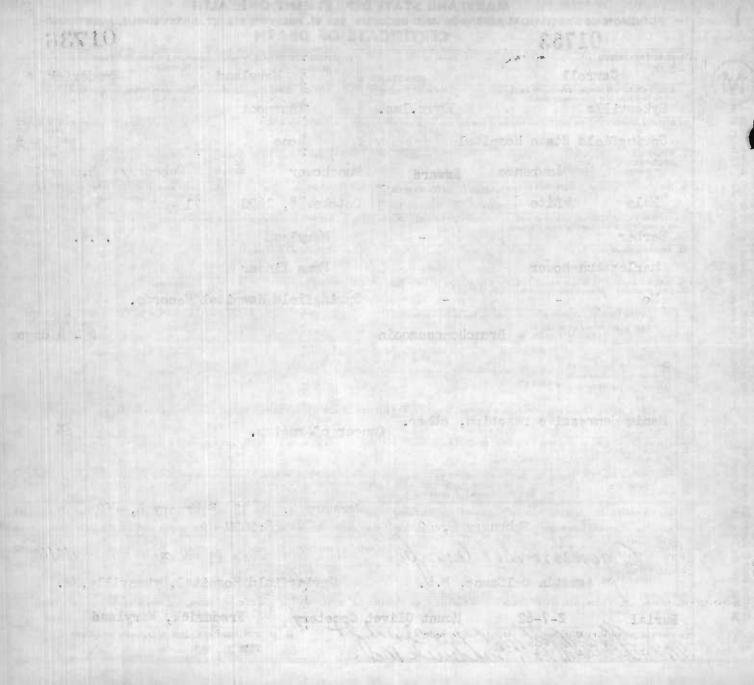
	PLACE OF DEATH			(Where decessed lived, If in b. COUNT	stitution: Residence before edmission)
	Carroll	MARYLAND	e. STATE Mary		Carroll
	b. CITY OR TOWN (if outside corporete limits, write RURAL end give neerest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If o	utside corporete limits, write l	RURAL and give neerest town)
_1	Wear Winfield	2 Yrs.	X Near Wi	nfield	
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp	pitel, give street eddress)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?
R	D. 5, Westminster		DDE	1.7 - m + 2	
3.	NAME OF First	Middle	Lasi	, Westminste	er Dey Yeer
	DECEASED (Type or print)	NATITICAL LATE	T T T T T T T T T T T T T T T T T T T	OF DEATH TO	10 40
	SEX 6. COLOR OR RACE 7. MARRIED	MEST MU	DATE OF BIRTH	9. AGE (In yeers	FUNDER 1 YEAR IF UNDER 24 HRS.
		NEVER MARRIED 8	DATE OF BIRTH		Months Deys Hours Min.
	Male White widows	7777	pril 28, 18	79 82 yrs.	
dor	USUAL OCCUPATION (Give kind of work 10b. Kill the during most of working life, even if retired)	ND OF BUSINESS OR INDUSTR	11. BIRTHPLACE (County	& State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
I	2	irmer	Maryland 14. MOTHER'S MAIDEN NA	AME	U. S. A.
	John T. Mullinix		T carres .	מייינו או	
15.	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. 5	SOCIAL SECURITY NO. 17. I	Laura NFORMANT	V. Dillon	
(Ye:	No (Ifyesgivewerordetesofservice)	Mn	. E. Ray Mu	llimis C	ama aa Na 1
-	18. CAUSE OF DEATH [Enter only one ceuse per li		· E. Nay Mu	TTTHITX, DE	ame as No. 1
	PART 1. DEATH WAS CAUSED BY:		7.0		ONSET AND DEATH
	IMMEDIATE CAUSE (a)	cardine	failure		2 Weeks
	LA LA DUE TO	1	Portic		10
	Conditions, if eny, which \ (b)	arteriord	votic	CVE	Hears
	geve rise to immediate cause				
	(e), steting the underlying Cause lest.				
z	PART II. OTHER SIGNIFICANT CONDITIONS CON	TRIBUTING TO DEATH BUT NO	T RELATED TO THE TERMINA	L DISEASE CONDITION GIVE	N IN PART 1(e) 19. WAS AUTOPSY
음					PERFORMED?
ŏ.			(F	1 B 1 H 7 1 40 1	YES NO
2	206. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	CRIBE HOW INJURY OCCURED	, (thier neture of injury in Per	t for Perf II of ITEM IB.)	
MEDICAL			CE OF INJURY (Home, farm, ory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
VED	Hour e.m. While et work	THOI WILLIAM	ory, street, office bidg., etc.)		,
~			2 /16/1/2 - 10	to 2/22/	62-10 Hat (1) (wa) last
7	21. I certify that (I) (this hospital) attend				
		2, and that	death occured at	from the causes a	nd on the date stated above.
	22e. SIGNATURE		ATTENDING ME	O STAFF	22b. DATE
	M. E. Robert	lan M	D. PHYS. DIR	ECTOR PHYS.	2/23/42
	22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		2 1
	M. E. Roberts	on, M. D.	Rec	Winds	er, md.
23e	BURIAL, CREMATION, 236. DATE THEREOF	23c. NAME OF CEMETERY	OR CREMATORY	23d. LOCATION (City, town	n or county) (State)
-	Burial Feb. 25, 1962	Prospect Co	meterv	Mt. Airv, N	Marvland
	FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		BY REGISTRAR 25b. REGI	
Ĉ.	M. Waltz, Box 241, 8		(C.3)		
	110 11011 1011 1011 1119	72200 122209 .	DATE	26'62 an	ilmy S. France

OTTES . A MANAGEM OF STILL LEGISLAND COMPANY OF SECTION OF S The state of the s weeken is Nay the House, we said the term 2 Wester Caroline Failure antimendantic CKE Line 2/16/62/150 2/25/12 M. E. Relandren 2/23/00 1. E. Bornettson, D. D. Tew Windrew Winds D. M. Walte, How fire, Sycastille, 17

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1753
CERTIFICATE OF DEATH
01736 01753 01736

	1.	PLACE OF DEAT	rroll		MARYLAND	a. STATE	rvland	ased lived, If i b. COUN	TY _	ederick	./
		b. CITY OR TOWN	if outside corporate limi	ts,	c. LENGTH OF STAY IN 16	c. CITY OR TOWN	(If outside corpora	te limits, write	RURAL end	ive nearest tow	n)
		Sykesvil			30yrs.lmo.	Thur	nont		10)	x.2	
-		d. NAME OF HOSPI	TAL OR INSTITUTION (if not in hos	pital, give street eddress)	d. STREET ADDRESS					SIDENCE A FARM?
			eld State F	lospit		None					NO X
	3,	NAME OF DECEASED	First		Middle	Last	4. DATE	Month		Dey Yee	
		(Type or print)	Lawren	ce	Edward	Munshower	DEATH	Febr	uary	4. 19	62
	5.	SEX	6. COLOR OR RACE	7. MARRIEI	NEVER MARRIED	B. DATE OF BIRTH	9. /	AGE (In years		AR IF UNDER	24 HRS.
		Male	White	WIDOWE		October 8, 1	L890 '	71 yrs.	Months Da	ys Hours	Min.
	10a	. USUAL OCCUPAT	ION (Give kind of worl	1Db, KI	NO OF BUSINESS OR INDUST	TRY 11. BIRTHPLACE (Cou	nty & State, or for	eign country)	12. CITIZE	N OF WHAT	OUNTRY?
		Barber	orang me, even a reme	۵/		Maryland	i		U.	S.A.	
	13.	FATHER'S NAME				14. MOTHER'S MAIDEN					
		Charles	Munshower			Emma Yin	nger				
	15.	WAS DECEASED EV	ER IN U.S. ARMED FOR	CES? 16.	SOCIAL SECURITY NO. 17.	INFORMANT		Address			
	{Ye	No No	If yes give we ror detes of s	ervice)	-	Springfield	Hospital	Recor	ds.		
		18. CAUSE OF I	DEATH [Enter only one	cause per li	ne for (e), (b), end (c).]					INTERVAL BET	
		PART I. DEAT	H WAS CAUSED BY,	Bron	chopneumonia					ONSET AND I	-
		Immediate cause (e) Bronchopneumonia 2 - 11 days									
	20	geve rise to immed	(0)								
		(e), steting the u	DI P TO								
		cause lest.) (c)								
)	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY Manic depressive reaction, other. Cancer of rectum.									
	RTIFIC	Cancer of rectume 20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert II or Pert II of item 18.) OR CONTRIBUTING CAUSE OF DEATH									
		(IF EITHER, NOTIFY	MEDICAL EXAMINER)								
	MEDICAL	20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, Porm, Porm									
		21. I certify	that (I) (this hospi	al) attend	ded the deceased from	January 4.	19.32 to Fe	bruary	4. 196	2. that (1) (we) last
					y4,19.6.2, and the						
		22e. SIGNATURE	ustin e	lel	amobo		MED. DIRECTOR	STAFF PHYS. X		2/5/	SHONED
		22c. PHYSICIANS	Agustin de	Camp	//	22d. ADDRESS Springfie	eld Hospi	ital,Sy	kesvil	le,Md.	
		BURIAL, CKEMAT REMOVAL (Specify Burial	2-7-62	REOF	Mount Olivet			rick, l	_		rete)
		FUNERAL DIRECTO	S SIGNATORS	akils	Sungones huled		C'D BY REGISTRA	AR 256. REG	SISTRAR'S SIG	GNATURE	
1	1%	1 K Jeh	1000 Xon	4/1	driek Md	DATE	FD3 7 '4	62	Caribury 1	& King	



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE 754 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If Institution: Residence before edmission) is nec. director. P. vour files. a. COUNTY e. STATE b. COUNTY Carroll Carroll Marvland MARYLAND b. CITY OR TOWN (if outside corporeta limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) write RURAL end give nearest town) Rural Keysville 50 years Rural Kevsville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) e. IS RESIDENCE ON A FARM? YES X NO Stat NAME OF First Middle Last 4. DATE Month Day Yeer DECEASED OF (Type or print) DEATH 1962 Ephriam Mvers February George 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED X 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. lest birthdey) Months Devs Hours Min. Male WIDOWED DIVORCED May 18. White 10e. USUAL OCCUPATION (Give kind of work 10b, KIND OF BUSINESS OR INDUSTRY | 11, BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) ve Pages 1 PM3. Pag Frederick County. Md. U.S.A. Farming Farmer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME page Give David P. Myers Elizabeth Stambaugh 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (Ifyes give wer or detes of service) Mrs. Iva Parker. Box 404 Sherwood Rd. Owings Mill No 219-12-0159 18. CAUSE OF DEATH [Enter only one cause par lina for (e), (b), end (c).] along fransit onary Occ busion PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Office DUE TO burial Conditions, if any, which (b) gave rise to immediate cause DUE TO (e), steting the underlying Examiner cause lest. pesn PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e): 19. WAS AUTOPSY CERTIFICATION PERFORMED? 20 emat NO T 20a. EXTERNAL CAUSE WAS 2Db. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury In Part I or Pert II of Item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. MEDICAL 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED I 20a, PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) (Stete) fectory, street, office bldg., etc.) While Not While Hour e.m. at work - at work OB: P 21. I certify that I took charge of the remains described above, held an Autopsy Inspection 1 Inquiry and in my opinion Suicide Undetermined manner death resulted from: Natural causes Accident Homicide EDIC forwarde CHIEF MEDICAL EXAMINER ACTUAL designated ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE FUNERAL DEPUTY MEDICAL EXAMINER EXAMINER'S NAME (Type) DEPU Address (Street, city, town, or county) 22a, BURIAL, CREMATION. CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (Stete) REMOVAL (Specify) Q40 0 Carroll Maryland Kevsville Cemeterv ADDRESS 24e. REC'D BY REGISTRAR I 24b. REGISTRAR'S SIGNATURE 23. FUNERAL/DIRECTOR VS. A15ME 5M 7/59 Son Tanevtown, Maryland DATE FFE 6 '62 Classing & Marie

MARYLAND STATE DEPARTMENT OF HEALTH

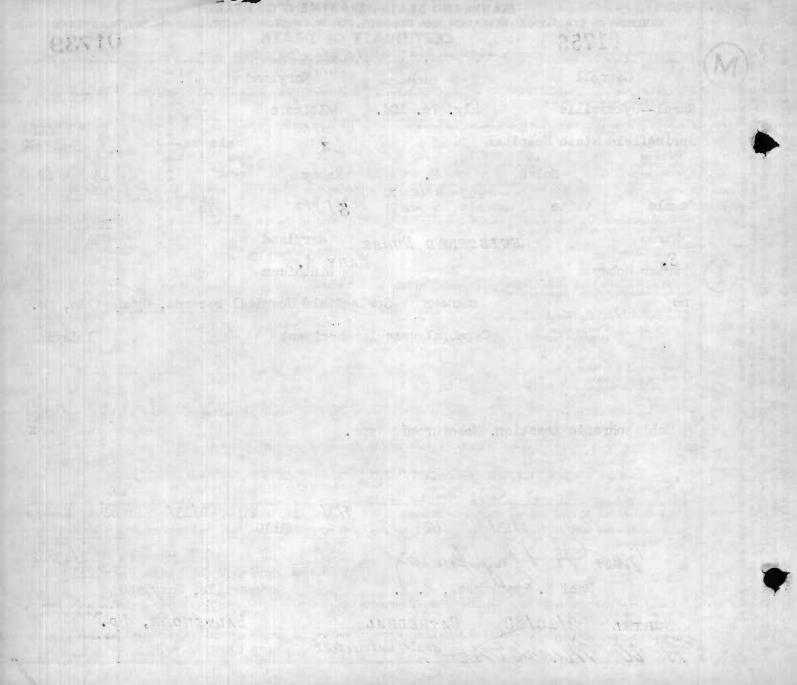
Later Commission of the Control of A MARINE TO THE PROPERTY OF TH part of the case of the case of the contract of the case of the ca And A section of the section of the

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 17755 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. FLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY Carroll MARYLAND Maryland Montgomery b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporata limits, write RURAL and give nearest town write RURAL and give nearest town) 7yrs.9mos.9days Rockville Sykesville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE 408 Park Road Springfield State Hospital YES NO X 3. NAME OF 4. DATE Middle DECEASED Minnie Carey Orrison February 13, 19 62 (Type or print) Gover DEATH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthday) | Months | Days December 18, 1869 Female White WIDOWED DO DIVORCED T 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) U.S.A. Housewife Virginia 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME William Gover Mary Stone 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (If yas give war or datas of service) Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure Hours DUE TO Years Conditions, if any, which (b) Arteriosclerotic heart disease gave rise to immediate cause Medical Examiner's DUE TO (a), stating the underlying causa last. cremation, PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY C.B.S.assoc.with dist.or metabolism, with senile brain disease with PERFORMED? CERTIFICATION psychotic reaction. Fracture, both inferior rami. Bilateral pneumonia. YES X NO EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enler nature of Injury in Part I or Part II of ilem 18.) should 208. EXTERNAL CAUSE WAS PRIMARY OF OF DEATH. MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., atc.) Not While Whila Maryland Sykesville Carroll at work of at work Hospital 21. I certify that I took charge of the remains described above, held an Autopsy X. Inspection X. Inquiry X. and in my opinion Accident Undetermined manner death resulted from Natural causes Homicide | CHIEF MEDICAL EXAMINER ances J. March ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER 2/13/62 EXAMINER'S James T. Marsh. M.D. NAME (Type) Address (Street, city, town, or county) 228. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (Stata) REMOVAL (Specify) 2/16/62 **540** Burial Lovettsville Union Cemetery Lovettsville, Va. 1331 E ADORS tgomery Avenue 240. REC'D BY REGISTRAR | 246. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR VS. A15ME arthur S. Phouse DATER 1 9 '62 Rockville. Md. 5M 7/59

RYLAND STATE DEPARTMENT OF HEALTH

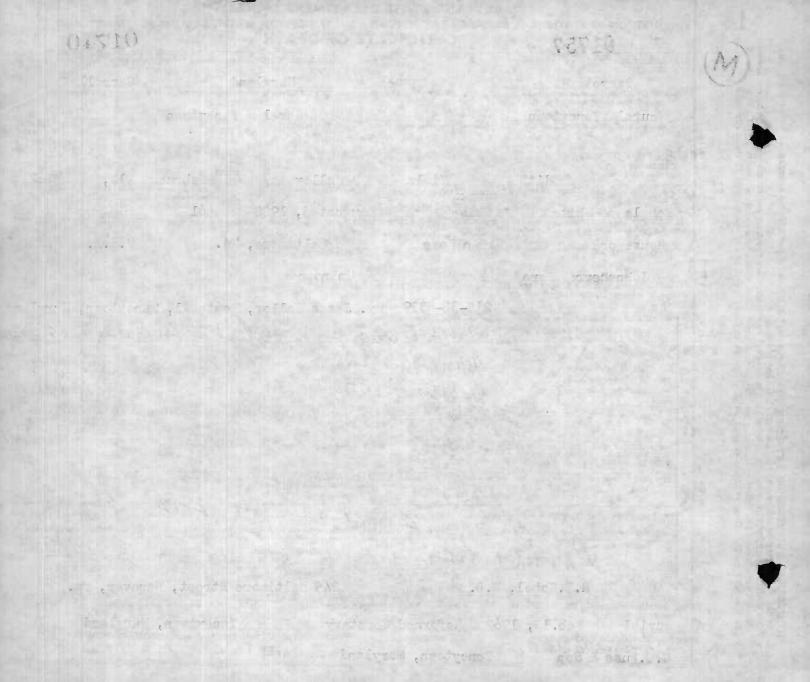
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e funeral	W.	1. PLACE OF DEATH a. COUNTY Carr		Item 2 Fil	m G307 2. UE	VAL RESIDEN STATE Mary		eased lived, If b. COUN	institution: Residen	ce before e	dmission)
in by the stand ifter death		b. CITY OR TOWN (if write RURAL and c	outside corporate limits, pive nearest town)	c. LENGTH OF ST	10d. E		(If outside corpo	rate limits, write	RURAL end give	neerest tow	n) 4
Med within	15	d. NAME OF HOSPITA Springfield 3. NAME OF	State Hosp		dress) d.	STREET ADDRESS	unk			YES _	NO K
execute complet on pape ithin 72		(Type or print)	Helen	Middle M MARRIED □ NEVER MARR		lobey	4. DATE OF DEATH	Month 2	13	19	62
ian and		female 10a. USUAL OCCUPATION	white	WIDOWED DIVORC	ED 5/3	/1887		74 yrs.	Months Deys	Hours	Min.
lets Wed in Poe. Fages 1		Nurse 13. FATHER'S NAME		EGISTERE D	NURSE MAR	Maryla			US.	A	
e di	I)	(Yes, no, or unkown) (Ify	IN U.S. ARMED FORCE	vice)	NO. 17. INFORM	Linthic		Address		URAL end give neerest town) 3 VO / - V a. IS RESIDENCE ON A FARM? YES \(\) NO \(\) Dey Year 13 19 62 UNDER 1 YEAR IF UNDER 24 HRS. Hours Min. 12. CITIZEN OF WHAT COUNTRY? USA Sykesville, Md. INTERVAL BETWEEN ONSET AND DEATH 3 days (County) (Stete) (County) (Stete) (County) (Stete) 19. WAS AUTOPSY PERFORMED? YES \(\) NO \(\) (County) (Stete) 10. ATE 2/13/62 11. ATE 2/13/62 12. CITIZEN OF WHAT COUNTRY? USA	
quires that hysician. hed by the it permit. n, or remo		18. CAUSE OF DE	WAS CAUSED BY:	ause per line for (e), (b), end	(c).]		spital r	ecords,	INI		
tend be uria		geve rise to immediat	e cause								
CIA bital ficat as to	0	ceuse last.	(c)		_	ED TO THE TERM	AINAL DISEASE C	ONDITION GIV		PERFO	RMED?
The first of the f											
	tc.)										
OR AITI		saw the decease			and that death	occured aB.	:10x, from			ate stated	above.
W. W.	1		Naci N.	June Knuse	M.D. PH	d. ADDRESS	Springfi	eld Sta	_	2/13, tal	/62
death		23s. BURIAL, CREMATIO REMOVAL (Specify)					23d. LOCA	TION (City, tov		(St	ate)
	R	24 FUNERAL DIRECTOR'S	Mear	17 Sque 805	n Coluent		FEB 1 5	00			
	20.			J. Con	ulej						



	1	
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after	death. Par may be retained by the hospital or attending physician. Yes TO FUNER. DIRECTOR: After this certificate has been signed by the attending physician and completely din by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Ages 1 and 2 chard director, page 3 should be detached for use as the burial, cremation, or removal, and in any event, within 72 hours after death	
ITAZI OR A	page 3 should with the State	
TO HOSP	death. P. TO FUNE	
	15M 9/60	

01757	SEARCH AND RECORDS, CERTIFICATE			BALTIMO	01'74	LAND	
PLACE OF DEATH		2. USUAL RESIDEN	CE (Whare dec	easad lived, If i		ca befora	admission
Carroll	MARYLAND	Mary	rland		Carrol		
b. CITY OR TOWN (if outside corporata limits, write RURAL and give neerest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN	If outside corpo	rate limits, writa	RURAL and give	nearest to	wn)
Rural Taneytown		Rura	Tane	eytown		1 - 10 0	RESIDENC
d. NAME OF HOSPITAL OR INSTITUTION (if not	in hospital, give street eddress)	d. STREET ADDRESS				ON	A FARM
3. NAME OF First DECEASED	Middle	Lest	4. DATE OF	Month	Dey	Yee	
(Type or print) Edith	Viola	Salley	DEATH	Februar	y 12	IF UNDER	Julia
SEX 6. COLOR OR RACE 7. N	ARRIED WEVER MARRIED B.	DATE OF BIRTH	9.		Months Deys	Hours	Min.
remale white	DOWED DIVORCED A	ugust 5, 190	00	61 yrs.			
De. USUAL OCCUPATION (Give kind of work lone during most of working life, even if retired)	106. KIND OF BUSINESS OR INDUSTRY	TI. BIRTHPLACE (Cour	ity & State, or fo	oreign country)	12. CITIZEN O	FWHAT	COUNTR
Housework	Own Home	Baltimon	e. Md.		U.S.A.		
3. FATHER'S NAME		14. MOTHER'S MAIDEN	NAME				
John Werry Hare		Unknown					
5. WAS DECEASED EVER IN U.S. ARMED FORCES? 'es, no, or unkown) (Ifyesgive werordetes of service	16. SOCIAL SECURITY NO. 17. IN			Address			
No (injusting the second secon	215_32_8339 Mm	James Salle	T Roud	- #1 T	oneutour	. Ma	mrla
18. CAUSE OF DEATH [Enter only one ceus	e per ine for (e), (b), end (c).	o alles parte				PRVAL	TWEEN
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Ceretral Remont	our St.	Tile 2	In Mouth	4090 50	6 79	har
DUE TO	11-11-	1	٠٠٠٠			4	
	Afteriosclerace	7				7 4	rs
geve rise to immediate cause	0 1 1- 00 00	1					
(e), steting the underlying DUE TO	Realites melli	tur				8.4	low
PART II. OTHER SIGNIFICANT CONDITION	CONTRIBUTING TO DEATH BUT NOT	DEL ATED TO THE TERMI	NAL DISEASE C	ONDITION GIVE	EN IN PART 1(a): 1	o was	AUTOPS
PART II. OTHER SIGNIFICANT CONDITION	S CONTRIBOTING TO DEATH BOT NOT	KEENIED TO THE TERMI	THE DISERSE O	ONDING!		PERFO	ORMED?
						YES	NO [
200. ACCIDENT WAS UNDERLYING 2010 OR CONTRIBUTING CAUSE OF DEATH	b. DESCRIBE HOW INJURY OCCURED.	(Enter neture of injury in	Pert I or Part II	of item 18.)			
(IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Dey, Year							
2001 /// 01 // 02 // 12 /		CE OF INJURY (Home, farr	n, 20f. (City	or town)	(County)		(Stete)
Hour a.m.	20d. INJURY OCCURRED 20e. PLACE While Not While at work at work	CE OF INJURY (Home, farr rry, street, office bldg., etc	n, 20f. (City	or town)	(County)		(Stete)
	While Not While facto	ry, street, office bldg., etc	.)	1-12	62	hat (I)	
21. I certify that (I) (this hospital)	While Not While facto at work at work at work at attended the deceased from	filly 7	19.57, to	2-12	, 19, 1		(we) 1
21. I certify that (I) (this hospital) saw the deceased alive on	While Not While facto	filly 7	19.57, to	2-12	, 19, 1	ate state	(we) l
21. I certify that (I) (this hospital) saw the deceased alive on	While Not While facto at work at work at work at attended the deceased from	death occured at.7. ATTENDING PHYS.	19.57, to	2-12	, 19, 1	ate state	(we) la
21. I certify that (I) (this hospital) saw the deceased alive on	While Not While at work factor at work 12 1907, and that T. Bollif M.	death occured at.7.	19, to 30.M, from MED. DIRECTOR	1-12 the causes STAFF PHYS.	19, 19, 1 and on the d	- 6 Z	(we) l
21. I certify that (I) (this hospital) saw the deceased alive on	While Not While at work factor at work 12 1907, and that T. Bollif M.	death occured at.7. ATTENDING PHYS. 22d. ADDRESS 245 Balti	19, to 36.M, from MED. DIRECTOR more St	1-12 the causes STAFF PHYS.	2-/3 anover, 1	- 6 2	(we) la
21. I certify that (I) (this hospital) saw the deceased alive on	white Not While at work factor at work at work at the deceased from	death occured at.7. ATTENDING PHYS. 22d. ADDRESS 245 Balti	19, to 30.M, from MED. DIRECTOR more St 23d. LOCA	the causes STAFF PHYS. reet, He	2-/3 anover, I	-62-	(we) lead about
Hour a.m. p.m. 19 21. I certify that (I) (this hospital) saw the deceased alive on	white Not While at work factor at work at work factor at white factor at work fac	death occured at.7. ATTENDING PHYS. 22d. ADDRESS 245 Balti CR CREMATORY tery	19, to 30.M, from MED. DIRECTOR MOTE St 23d. LOCA Tand	the causes STAFF PHYS. reet, Harrion (City, tover)	2-/3 anover, 1	- 6 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	(we) lead about
21. I certify that (I) (this hospital) saw the deceased alive on	white Not While at work factor at work at work at the deceased from	death occured at.7. ATTENDING PHYS. 22d. ADDRESS 245 Balti OR CREMATORY 1250. RE	19, to 30.M, from MED. DIRECTOR MOTE St 23d. LOCA Tand	the causes STAFF PHYS. reet, Harring to the causes ret, Harring to the causes ret	and on the day and on the day and on the day and an arrow ar	Pa.	(we) lead about



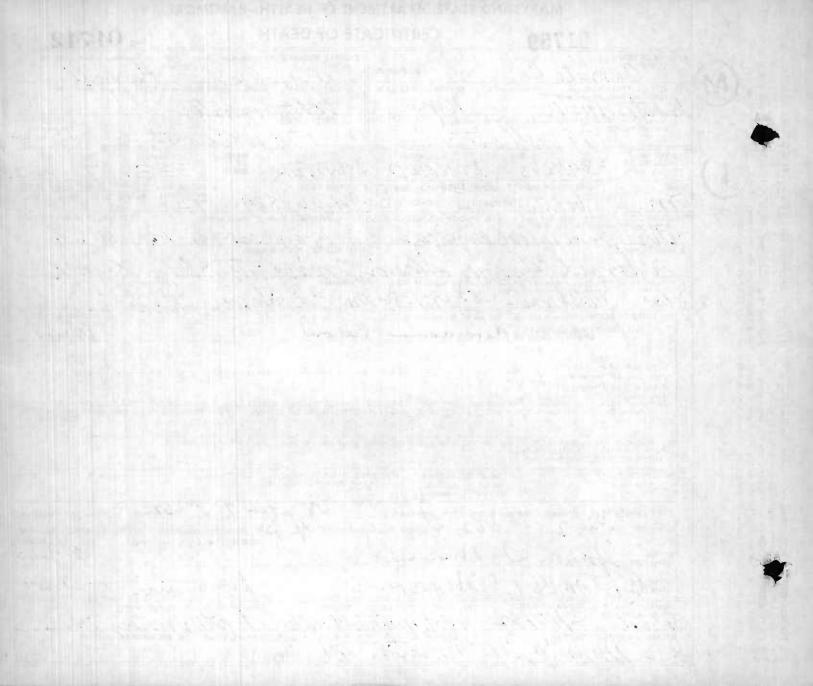
CH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND USUAL RESIDENCE (Where dacaased lived, If institution, Rasidence before admission)

ARYLAND

ARYLAND 1. PLACE OF DEATH a. COUNTY Page is necessary, CARROLL MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, writa RURAL end give nearest town) director. write RURAL and give nearest town) MYERSVILLE 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give streat address) d. STREET ADDRESS a. IS RESIDENCE 0 ON A FARM? SPRINGFIELD STATE HOSPITAL YES NO NAME OF Middla 4. DATE Last Month DECEASED OF (Typa or print) PAULINE DEATH 19 62 MIRIAM SHEPLEY after with 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 9. AGE (In years I IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months December WIDOWED X Female 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY I BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? Office along with form PM3. Page burial-transit permit. File pages 1 an done during most of working life, evan if retirad) in pencil in Item 18. Give Pages 1, housewife own home Frederick, Co. Md. pages 1 within 13 FATHER'S NAME Walter Lizer Estie Shepley 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yas, no, or unkown) | (If yas give war or dates of sarvica) Clarence F. Shepley, Myersville, Md. no certificate should be executed 18. CAUSE OF DEATH [Entar only one causa per lina for (a), (b), and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Gunshot wounds of neck (b) "pending" gave risa to immediata cause Examiner's DUE TO (a), stating the underlying 占 cause last. cremation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY CERTIFICATION PERFORMED? 9 scute the certificate, writing the word NO plnods 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Pert I or Pert II of Itam 18.) 20a. EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING CAUSE OF DEATH. Shot self in neck 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) (Steta) factory, street, office bldg., atc.) rederick 19 62 at work et work Home DIRECTOR: 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion forwarded Suicide X death resulted from: Natural causes Accident Homicide Undetermined manner CHIEF MEDICAL EXAMINER designated ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED PUNERAL SIGNATURE DEPUTY MEDICAL EXAMINER NAME (Typa) Peter W. Rieckert, M.D. Add Addrass (Street, city, town, or county) 22e. BURIAL, CREMATION. 22d. LOCATION (City, town, or country) (State) REMOVAL (Specify) ₽40 6 Burial Feb.7,1962 St. Paul's Lutheran Myersville, 23. FUNERAL DIRECTOR REGISTRAR'S SIGNATURE 24b. VS. A15ME en was S. Maries Bittle . Myersville . Md . 5M 9/60

13511 distresses Tedenber 31, 1904:037 .A.B. T. A. Di. . Ol. Medaleberg velquis estas Taghi gadimi 220-42-2592 Clerende F. 35s Loy, Mysrsville, M. Mariabes T And the state of t . Bu . efftveray . efftle . T fuel

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01760 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where dacesed lived, If institution: Residence before admission) a. COUNTY b. COUNTY Carroll Frederick Maryland the d 2 MARYLAND b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 write RURAL and give nearest town) Months Sykesville Libertytown within d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give strael addrass) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? Pullen Nursing Home YES NO 3. NAME OF Middle Last Day 4. DATE Month DECEASED OF compi (Type or print) Joanna Norris Simpson DEATH 28. 19 62 February and co 5. SEX 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED AGE (In yeers | IF UNDER 1 YEAR IF UNDER 24 HRS. 8. DATE OF BIRTH last birthday) Months Hours WIDOWED Female DIVORCED 1Da. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, evan if retired Frederick Co. Maryland US. A. Housewife None 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Nicholas Edgar Norris Fannie Browning 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (Ifyas giva war or dates of service) None Libertytown, r. F. Loraine Simpson Maryland
INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] ONSET AND DEATH PART t. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Conditions, if eny, which geve rise to immediate cause DUE TO (e), stating the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE VAS AUTOPSY CATION PERFORMED? NO P 20e. ACCIDENT WAS UNDERLYING T 2Db. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH MEDICAL 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm,) 2Df. (City or town) (Stete) (County) fectory, street, office bldg., etc.) While Not While Hour a.m. 21. [certify that (I) (this hospital) attended the deceased from AMM19.10 and that death occured at JOM, from the causes and on the date stated above. saw the deceased alive on. 22e. SIGNATUR 22b. DATE ATTENDING SIGNED PHYS. DIRECTOR PHYS. 22c. PHYSICIAN 22d. ADDRESS 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23b. DATE THEREOF (State) REMOVAL (Specify) Libertytown, Maryland Fairmount Cemetery **ADDRESS** 25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 9/60 Frederick, Maryland Son DATE Cushud & Traces

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 01744 01761

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived, If institution: Rasidence before edmission) e. STATE b. COUNTY
MARYLAND MARYLAND	" Mit Counte
b. CITY,OR TOWN (if outside corporata limits, c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporata limits, write RURAL and give neerest town)
write RURAL and give nearest town)	V LANT. T.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS 0. IS RESIDENCE
A The street address	ON A FARM?
Carrellound, Jeul Haspelel	YES NO NO
NAME OF DECEASED First Middle	Last 4. DATE Month Day Year OF
(Type or print) CALVIN G SLI	WAICER DEATH TIL 9 1962
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8.	DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.
WIDOWED TO DIVORCED	1 A - 1 3 - 6 7 GL yrs. Months Days Hours Min.
100. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTR'	
done during most of working fifa, even in retired)	m. 1 115A
(Slock Suith (fitters))	JKK. (N.S., 17
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Slonaker	Susan Eckard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. I	NFORMANT Address
(Yes, no, or unkown) (If yes give wer or detas of servica)	0 7 7/2 77 1 1 1 27 2
	cora Lawyer, R#1, Westminster, Maryland
PART I, DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (0)	The lookic Vascular Clisiace year
LI-D DUE TO	
geve risa to immadiate ceuse	
(e), steting the underlying DUE TO	
couse test. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO	T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
A PARTICIPATION OF THE PARTICI	YES NO NO
20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED	. (Enter nature of injury in Pert t or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	CE OF INJURY (Home, ferm, 20f. (City or town) (County) (Stata)
Hour e.m. While Not While tech	ory, street, office bldg., etc.)
	1.12 210
21. I certify that (I) (this hospital) attended the deceased from	1967 107 14 9 1962, that (1) (we) last
saw the deceased alive on 7.4 9 196 2, and that	death occured at
22e. SIGNATURE	22b. DATE
busy I March	D. ATTENDING MED. STAFF DIRECTOR PHYS. 1 2-9-65
22c. PHYSICIAN'S	22d. ADDRESS.
(NAME (TYPO) SAMES I MARSH	descharates mi
230. BURNAL CREMATION, 236. DATE THEREOF 23c. NAME OF CEMETERY	OR CREMATORY 23d. LOCATION (City, town or county) (State)
REMOVAL (Specify)	sterv Silver Run. Marvland
	256. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	13 162 (144 9 %
C.O. Fuss & Son Taneytown, Maryla	and DATE FEB 1 3 '62 Colling S. Thank

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O HOSFITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after		O 1: ERAL DIRECTOR: After this certificate has been signed by the attending physician and comp	plnods	-	_
4 hour		by the	and 2	grade	1
ithin 2		lled in l	ages 1	s after	-
w bett	4	v fi	pers. P	2 hour	
exect		Сотр	on Dai	vithin 7	
cate be		ian and	ve cark	vent, v	
certifi		physic	e remo	any e	
e death		ending	n pleas	and ir	
that the		the att	it. The	emoval	
equires	hysicia	ned by	iit perm	on, or r	
e law r	death age 4 may be retained by the hospital or attending physician.	seen sig	ial-trans	be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.	
N: Th	or afte	e has b	the bur	burial,	
SICIA	ospital	ertificat	use as	rior to	
T PHY	y the h	r this c	ed for	ealth pi	
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OH O	derth	0	directo	be file	

VR A15 (4) 15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where daceased lived, If institution; Residence before edmission) a. COUNTY b. COUNTY Carroll Maryl and Balto City MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville 3yrs.7mos.23days Baltimore 13 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Springfield State Hospital 1740 Harford Avenue YES NO X 3. NAME OF Middle 4. DATE DECEASED (Type or print) Frank Snyder DEATH 1962 February 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Male White WIDOWED TX DIVORCED F 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or toreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Foreman U.S.A. Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Frank Snyder Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (If yes give wer or detes of service Springfield Hospital Records 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Pneumonia IMMEDIATE CAUSE (a) Davs DUE TO Congestive heart failure Conditions, if eny, which 1 week geve rise to immediate cause DUE TO (a), stating the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with dist.of metabolism, with senile 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO X 200. ACCIDENT WAS SIDERLYING TO 200. DESCRIBE HOW INTERFECTION. (Enter neture of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH MEDICAL 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED I 20e, PLACE OF INJURY (Homa, ferm, 20f. (City or town) (County) (Steta) factory, street, office bldg., etc.) Hour a.m. Whila _Not While et work et work 21. I certify that (I) (this hospital) attended the deceased from June 19. 19.58 to February 129.62that (I) (we) last saw the deceased alive on February ... 11. 19... 62., and that death occured & JOAM from the causes and on the date stated above. 22a. SIGNATURI 22b. DATE ATTENDING 2/12/8/9 DIRECTOR PHYS. 220. PHYSICIAN'S 22d. ADDRESS Agustin delCampo. M. Springfield Hospital, Sykesville, Md. 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

TO FUNER.

VR A15 (4) 15M 9/59

01763 CERTIFICATE OF DEATH

01746

	o. COUNTY ()	UAL RESIDENCE (Where deceased lived. If institution: Residence befare admission) STATE b. COUNTY
	Carroll MARYLAND	Marylanc Carroll
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town 1940	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nombertea D. Rura /
		STREET ADDRESS e. IS RESIDENCE ON A FARM?
	Long VIEW Nursing Nome 14	oucheville ave YES NO
	3. NAME OF DECEASED (Type or print) LINNIE FOR STATE OF THE STATE OF	Last 4. DATE Month Day Year OF THE PROPERTY OF
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DAT	OF FIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.
	Female whit WIDOWED DIVORCED JU	we 24 1863 [ast birthday] Months Doys Haurs Min.
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	1. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY?
	13. FATHER'S NAME	MOTHER'S MAIDEN NAME
	JAMES HOLLINAN	Fleamer Davidson
1	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORM	Address
	(Yes, no, or unknown) (If yes, give wor or doles of service) 2/9-36-1364 /1/	Milson Kill HAMPSTEAD MC
	18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	140 carditis
	422 DUE TO 0	Ω
	Canditians, if any, which) (b) Urterio scleratio	(artio Vascula Desease ?
d	gove rise to immediate couse (a), stating the under-	
		seasu.
)	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT R	ELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?
	(LY)	YES NO
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT R 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	or nature of injury in Part I ar Part II of item 18.)
		INJURY (Home, farm, 20f. (City or tawn) (County) (Stote)
	20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED Hour a. m. 19 While Not while at wark at work	treet, office bldg., etc.)
	21. I certify that (1) (this hospital) ottended the deceased from Se	15/ 1 1950 to Feb 4 1962 that (1) (we) last
	saw the deceased olive an Tab 2 1962 and that death	occurred at 36 M, from the couses and on the dote stated above.
	22a. SIGNATURE	22b. DATE
	Lough Couch M.D.	ATTENDING MED. STAFF SIGNED PHYS. D
	PAME (Type) MERCH F TBUS 6 MYD	Want stal Man land.
	23a. BURAL REMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREA	AATORY 23d. LOCATION (City, town, or county) (State)
	gemoval (specify) 2-7-62 Messley	Quinall to Mid
	24. FLINERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS	250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE
	Instead Elen Hampitead	DATE FED 7 '52 Curhun & Maria

NUMBER OF STREET Love to the state of the state of Janes Helfinn Start Janes There

01764 CERTIFICATE OF DEATH Reg. Dist. No. director, iled with PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) filed a. COUNTY o. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? YES NO NAME OF First Middle 4. DATE Month Day Year (Type or print) DEATH GLUFF 19 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years lost birthdoy) IF UNDER 1 YEAR IF UNDER 24 HRS Months Days WIDOWED D DIVORCED | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY 13. FATHER'S NAME CROMWELL Address 40015 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate **DUE TO** cause (a), stoting the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19, WAS AUTOPSY PERFORMED? YES NO I 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port 11 of item 18.) 20c. TIME OF INJURY Month, Day, 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) g. ft. While Not while of work of work p. m 6 3That I last saw the deceased 21. I certify that I attended the deceased from alive on s and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL PHYSICIAN'S NAME (Type) 22a. BURIAL CREMATION. 22b, DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24b. REGISTRAR'S SIGNATURE 24g. REC'D BY REGISTRAR 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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A CONTRACTOR OF THE PROPERTY O		
	200 A	

174	1.	PLACE OF DEAT	£ 165		2. USUAL RESIDEN	CE (Where deceased lived, If	institution: Residen	ce before edmission
1		DOOLT			a. STATE	b. COUN	YTY	
XXXX		ARROLL b. city or town	(if outside corporate limit	MARYLAND s, c. LENGTH OF STAY IN 1b	Maryland	(If outside corporate limits, write	rroll	nearest town)
ALX		write RURAL en	d give nearest town)		27		e KOKAL GIIG GIVE	nesie a lowny
1/		STMINIST		not in hospital, give street address)	d. STREET ADDRESS	STER		. IS RESIDENCE
X				no. Il nospital, give sivel addiess;	O. SIKEET ADDRESS			ON A FARM?
	3.	NAME OF	First	Middle	Mayberry	Road Month		YES NO
1		DECEASED (Type or print)	F1134	WIGGIA	Lasi	OF		Year
1		SEX	DAVII)	TWNKOSIC		5(Presum	
1	٥.	JEX	o. COLOR OR RACE	TO MICHEL MARKIED	B. DATE OF BIRTH	9, AGE (In years last birthdey)	Months Deys	Hours Min.
	10	Male	White	WHOWEN PHUN MENTREED CA	unknown	1.7 yrs.		
	do	ne during most of we	ION (Give kind of work orking life, even if relired	106. KIND OF BUSINESS OR INDUST	RY 11. BIRTHPLACE (Siete	or foreign country)	12. CITIZEN O	F WHAT COUNTRY
					lyhikh/b/wh/	Yugoslavia	Lun	known
	13.	FATHER'S NAME			14. MOTHER'S MAIDEN	NAME		
7								
9	15. (Ye	WAS DECEASED EV s, no, or unkown) (ER IN U.S. ARMED FORG	CES? 16. SOCIAL SECURITY NO. 17.	INFORMANT	Address		
				cause per line for (a), (b), end (c).]				ERVAL BETWEEN
		PART I. DEAT	H WAS CAUSED BY: IMMEDIATE CAUSE (a)_	Gunshot wound	of chest			OLI AND DEATH
		976	V DUE TO					
		Conditions, if en	which (b)					
		gave rise to immed						
		cause lest.	(c)					
	Z	PART II. OTHE		IONS CONTRIBUTING TO DEATH BUT NO	OT RELATED TO THE TERMI	NAL DISEASE CONDITION GIV	EN IN PART 1(e) 1	
	Ĕ						1	PERFORMED?
	CERTIFICATION	20a. EXTERNAL C.	AUSE WAS 20	b. DESCRIBE HOW INJURY OCCURED.	Enter neture of Injury in Per	t I or Part II of item 18.)		- H
-	CER	PRIMARY TO OF CO	IS I	not self in chest	- during a	period of des	spondency	T
	A			LOOK WILLIAM OCCURRED LOOK BL	or or named the	n, ; 20f. (City or town)	(County)	
	U	20c. TIME OF INJU	JRY Month, Day, Yee	20d. INJURY OCCURRED 20e. PL/	ACE OF INJURY (Home, farm			(Siele)
	EDIC	Hour a.m.		While Not While fac	lory, street, office bldg., etc	.)		
	MEDICAL	? Hour a.m.	2 251962	While Not While fac	lory, street, office bldg., etc Home	Westminister		1 Md.
	MEDIC	? Hour a.m. p.m.	2 25 1962 nat I took charge of	while at work of the remains described above, he	Home Home Autopsy	Westminister	ry , and	
	MEDIC	? Hour a.m.	2 25 1962 nat I took charge of	while at work of the remains described above, he	Home Home ald an Autopsy X, Homicide	Westminister Inspection	ry , and	1 Md.
	MEDIC	? Hour a.m. p.m. 21. I certify the death resulted	2 25 1962 nat I took charge of	while at work of the remains described above, he	Home Home Home Homicide CHIEF MEDICAL	Westministe Inspection, Inquir, Undetermined mexaminer	ry, and nanner	1 Md. in my opinion
	MEDIC	? Hour a.m. p.m.	2 25 1962 nat I took charge of	while at work of the remains described above, he	iory, street, office bldg., etc Home eld an Autopsy X, cide X. Homicide CHIEF MEDICAL M.D. ASSISTANT MED	Westministe	ry, and nanner	1 Md.
)	MEDIC	? Hour a.m. p.m. 21. I certify the death resulted ACTUAL SIGNATURE EXAMINER'S	2 25 1962 mat I took charge of from: Natural cau	while Not While at work the remains described above, he uses , Accident , Suice	Home eld an Autopsy X, cide X, Homicide CHIEF MEDICAL	Westministe	ry, and nanner	1 Md. in my opinion ATE SIGNED
2		Hour a.m. p.m. 21. I certify the death resulted actual SIGNATURE EXAMINER'S NAME (Type)	2 25 1962 nat I took charge of from: Natural cau PETER W. RI	while Not While face at work of the remains described above, he asses Accident Suice ECKERT, M.D.	ide X. Homicide CHIEF MEDICAL ASSISTANT MED DEPUTY MEDICA Address (Street,	Westminister Inspection	ry, and nanner D	1 Md. in my opinion ATE SIGNED 2-26-62
2		Hour a.m. p.m. 21. I certify the death resulted actual SIGNATURE EXAMINER'S NAME (Type)	2 25 1962 nat I took charge of from: Natural cau PETER W. RI	while Not While face at work of the remains described above, he asses Accident Suice ECKERT, M.D.	ide X. Homicide CHIEF MEDICAL ASSISTANT MED DEPUTY MEDICA Address (Street,	Westminister Inspection	ry, and nanner D	1 Md. in my opinion ATE SIGNED
2	22a	Hour a.m. p.m. 21. I certify to death resulted ACTUAL SIGNATURE EXAMINER'S NAME (Type) BURIAL CREMATIC REMOVAL (Specify	2 25 1962 nat I took charge of from: Natural cau PETER W. RI 22b. DATE THEREO 2 27.6	while Not While at work of the remains described above, he uses, Accident, Suice, Accident	ide X, Homicide CHIEF MEDICAL M.D. ASSISTANT MED DEPUTY MEDICA Address (Street, CREMATORY)	Inspection . Inquir Inspection . Inquir Inspection . Inquir Inquir Incal EXAMINER . L EXAMINER . Cilly, town, or county) 22d. LOCATION (City, town	ny, and nanner D , or country)	n Md. in my opinion ATE SIGNED 2-26-62 (Siele)
2	22a	Hour a.m. p.m. 21. I certify the death resulted actual SIGNATURE EXAMINER'S NAME (Type) BURIAL CREMATIC	2 25 1962 nat I took charge of from: Natural cau PETER W. RI 22b. DATE THEREO 2 27.6	while Not While face at work of the remains described above, he asses Accident Suice ECKERT, M.D.	ide X, Homicide CHIEF MEDICAL M.D. ASSISTANT MED DEPUTY MEDICA Address (Street, CREMATORY)	Inspection . Inquir Inspection . Inquir Inspection . Inquir Inquir Incal EXAMINER . L EXAMINER . Cilly, town, or county) 22d. LOCATION (City, town	ry, and nanner D	n Md. in my opinion ATE SIGNED 2-26-62 (Siele)
2	22a	Hour a.m. p.m. 21. I certify to death resulted ACTUAL SIGNATURE EXAMINER'S NAME (Type) BURIAL CREMATIC REMOVAL (Specify	2 25 1962 nat I took charge of from: Natural cau PETER W. RI 22b. DATE THEREO 2 27.6	while Not While at work of the remains described above, he uses, Accident, Suice, Accident	ide X, Homicide CHIEF MEDICAL M.D. ASSISTANT MED DEPUTY MEDICA Address (Street, CREMATORY)	Inspection Inquir Inspection Inquir Inspection Inquir Inqu	ny, and nanner D , or country)	in my opinion ATE SIGNED 2-26-62 (Siele)

THE PARTY OF THE P Figure 1 references to the state of the state of

the funeral director, should be filed with OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 **D FUNERAL ARECTOR:** After this certificate has been signed by the ottending physician and completely filled a page 3 should be detached for use as the buriol-transit permit. Then please remove carbon papers. Pages 1 at the State Board of Health prior to buriol, cremation, at removal, and in any event within 72 hours after death. ed by the hospital or attending physician. TO HOSPITAL TO FUNERA

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH 01766 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

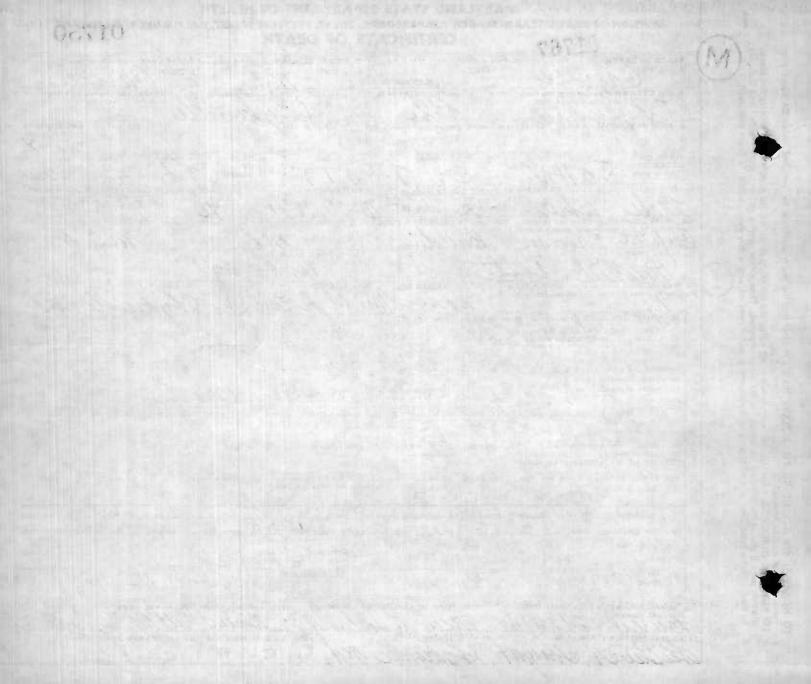
01749

	1. PLACE OF DEATH o. COUNTY			CE (Where deceased lived.		befare admission)
1	(Arroll	MARYLAND	a. STATE	uland.	· COUNTY OAKK	011
	b. CITY OR TOWN (If outside corporate limits, write RUBAL and give nearest tawn)	H OF STAY IN 16	c. CITY OR TOW	(If outside corporate lim	its, write RURAL and give	e nearest town)
	HAMPSTEAD L.	le:	X HAM	DSFFAD		
,	d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION		d. STREET ADD	ESS		e. IS RESIDENCE
	12 Houdesville AVE		11 140	uclesuille.	aue.	ON A FARM? YES \(\) NO
	3. NAME OF First	Middle	Lost	4. DATE	Month	Doy Year
	DECEASED		1 1 1	OF DEATH	7 / Month	
		NNEW	IPTOI		rory,	YEAR IF UNDER 24 HRS.
	741		8. DATE OF BIRTH		1 11 1	ays Haurs Min.
	Male White WIDOWED	DIVORCED [That !!	070 7	yrs.	
	10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF I during most of working life, even if retired)	BUSINESS OR INDUS	STRY BIRTHPLACE	(State or foreign country)	12. CITIZE	N OF WHAT COUNTRY?
		eval.	1110	Wland		915A.
-	13. FATHER'S NAME	7-1	14. MOTHER'S MA	IDEN NAME		
	William FBTint	nn	1	. 73	1	
)	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SE	CURITY NO. 17. IN	IFORMANT AU	a pen	Address	
	(Yes, no, or unknown) (If yes, give war or dates of service)	1-47 17 /	W O+-	1-1-1	. 11	-1- n. M.
7	NO 214-34	7/13/	IND, HDD.	1E. IIPTON	MAMP	STEADING
П	18. CAUSE OF DEATH Enter only one couse per line for (a)	(b), and (c),	2 -1	1		ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	enterne	- Henr	recharge		72 lus
	DUE TO	^	0.	200		
	Conditions, if any, which) (b) They had	Course	Careli	1 / Locula	Omis	
4	gave rise to immediate cause (o), stating the under-					
	lying cause last.	solul	tie (and	wasculu a	Vescore	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUT	ING TO DEATH BUT	NOT RELATED TO TH	E TERMINAL DISEASE COND	DITION GIVEN IN PART 1	(a) 19. WAS AUTOPSY
)	TA TA	-				PERFORMED? YES NO D
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUT 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOV OR CONTRIBUTING CAUSE OP DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)	V INJURY OCCURRED	D. (Enter noture of ini	ury in Port I ar Port II of it	rem 1B.)	
	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		_			
		CLIPPED 20e PL	ACE OF INITIBY /Hom	e, farm, 20f. (City or tow	(C-)	unty) (State)
	Hour a.m. While Not	while foo	ctory, street, office blo	lg., etc.)	ii) (Cat	unty) (State)
	p. m. ot work at wo	ork 📴				
П	21. Leertify that (1) (this haspital) attended the a	deceased fram.	February 4	1962 to 21	- 7 1962	that (I) (we) last
	saw the deceased alive an fel- 6. 190	22 and that d		M, fram the co	auses and an the o	date stated above.
-9	22% SIGNATURE	//				22b. DATE
	Joek / Chi	st	M.D. ATTENDING	MED. STAI	FF S. □	SIGNED
	22c. PHYS CIAN'S	1	22d. ADDKESS	,		
16	NAME (Type) OSCOL E. Bus.	/ IVID	HA	MDSFEAN	MAL	yland
1		ME OF CEMETERY O	D CREMATORY	234 LOCATION (C	lity, tawn, or county)	(Stote) A
	MOVAL (Specify)	Herech	ATend	ann	a 00 0 1	7/1/
	24-EUNERAL DIRECTOR'S SIGNATURE ADD	RESS	2 / 30	REC'D BY REGISTRAR	2Sb. REGISTRAR'S SIGN	ATILIPE
1	Million - Plus - Helen	resterd!	VVIA	4 0 100	anthury 8. The	
1.	· /Joy · or or course / 1 - 1		DA	FEE 1 3 '02	annul a. Iva	ALM.

ELVIO. THAT PROPERTY THE STATE OF THE STATE OF

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARY CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence belora admission) a. COUNTY b. COUNTY a. STATE the dath. MARYLAND b. CITY OR TOWN (il outside corporate limits, with RUBAL and pive neers town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN Moutside corporate limits, write RURAL and give nearest town) d. NAME OF MOSPITAL OR INSTITUTION (if not in hospital, give street eddress) . IS RESIDENCE d. STREET ADDRESS ON A FARM? YES NO 3. NAME OF First Middle 4. DATE Last Month Day DECEASED [Type or print] DEATH 1960 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER last birthday) Months Days Hours WIDOWED X DIVORCED | SUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? BIRTHPLACE (County & State, or foreign country) most workingdila, avan il retirad) HER'S NAME please 14. MOTHER'S MAIDEN NAME 2 attending ARMED FORCES? 16. SOCIAL SECURITY NO. Addrass (Yas, no, or unkown) | (Il yas giva war or datas of service) 18. CAUSE OF DEATH [Enter only one cause par line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: decen IMMEDIATE CAUSE (a) DUE TO Conditions, il any, which gave rise to immadiata causa DUE TO (e), stating the undarlying causa lest. PART II. OTHER SIGNIFICANT, CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION 19. WAS AUTOPSY PERFORMED? NO 200. ACCIDENT WAS UNDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH efached 20c. TIME OF INJURY Month, Dey, Yaar 20d. INJURY OCCURRED | 20a, PLACE OF INJURY (Home, farm, ! 201. (City or town) (County) (Stata) factory, streat, office bldg., atc.) Hour a.m. While Not Whila et work at work 19.6.2., and that death occured at 1.1.1.1. from the causes and on the date stated above. saw the deceased alive on. 22a. SIGNATURE 22b. DATE ATTENDING MED. SIGNED STAFF PHYS. DIRECTOR PHYS. 22c. PHYSICIAN'S 22d. ADDRESS NAME (Typa) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR GREAMETORY 24 FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE VR ATS (4) 1SM 7/61 arthur & Thous

RYLAND STATE DEPARTMENT OF HEALTH



lled in by the funeral ages I and 2 should within 24 hours after TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2, death.

4 may be retained by the hospital or attending physician.

TO FUNE. AL DIRECTOR: After this certificate has been signed by the attending physician and complement of director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers rages the befiled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after

VR A1S (4) 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 01768 CERTIFICATE OF DEATH

-2000							
PLACE OF DEATH	2. USUAL RESIDEN	ICE (Where decee			dence before	edmission)	
Carroll MARYLAND	a. STATE Marvland	3	b. COUN	leganta	-		
b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16	c. CITY OR TOWN				ve nearest to	wn)	
write RURAL and give neerest town)	Falchent	Minor		1	x .2		
Springfield, Sykesville 7 mos. 9dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address)	Eckhart d. STREET ADDRESS			01.	e. IS R	ESIDENCE	
	E 305					A FARM?	
Springfield State Hospital	Box 135					NO X	
NAME OF First Middle DECEASED	Last	4. DATE OF	Month		ey Yee	er	
(Type or print) Sarah Harris	Twigg	DEATH	Februa	ry 22	2 19	62	
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	DATE OF BIRTH		GE (In years st birthday)	IF UNDER 1 YEA		R 24 HRS.	
	June 19, 1884		yrs.	Months Dey	rs Hours	Min.	
De. USUAL OCCUPATION (Give kind of work 10b, KIND OF BUSINESS OR INDUST	RY 11. BIRTHPLACE (Cou	nty & Stete, or fore	ign country)	12. CITIZEN	OF WHAT	COUNTRY	
done during most of working life, even if retired)							
Housewife -	Maryla			U.	S.A.		
S. FAIRER S NAME	14. MOTHER'S MAIDEN	INAME					
William Harris	Catherine	e Cross					
S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. 17. 17. 18. 18. 19. 1	INFORMANT		Address				
	oringfield He	nenital B	econd.	9			
18. CAUSE OF DEATH [Enter only one couse per line for (e), (b), end (c).]	ATTIBLICATO IN	opproar u	ecoru;		INTERVAL BE		
PART I. DEATH WAS CAUSED BY:					Years	DEATH	
IMMEDIATE CAUSE (e) Cardiac insuffic:	lency				10919		
DUE TO					***		
Conditions, if any, which) (b) Old age inanition	1.				Years.	•	
geve rise to immediate cause (e), stating the underlying DUE TO							
cause lest. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO	OT RELATED TO THE TERM	INAL DISEASE CO	NDITION GIV	EN IN PART 1(e	19. WAS	AUTOPSY	
C.B.S. with senile brain disease with	nevehotic	reaction			YES T	NO T	
20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCUREI					1	1.24	
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	OR CONTRIBUTING [] CAUSE OF DEATH						
20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PL While Not While fee	ACE OF INJURY (Home, fer		town)	(County))	(State)	
Hour e.m. While Not While p.m. 19 et work et work	iory, ander, office bregs, on	1					
	7-13-	1067 10	2-2	22- 10 6	2 that (1)	(wa) la	
21. I certify that (I) (this hospital) attended the deceased from		O'I'D' B'. M.		IZ	3 IIIai (1)	J -1	
saw the deceased alive on 2-22-19.62, and the	death occured att.	V.AM, from it	ie causes	and on the		b. DATE	
22e. SIGNATURE	ATTENDING_	MED.	STAFF		22	SIGNE	
hall of Jugutimmer	1.0.	DIRECTOR	PHYS.		2.	-22-0	
22c. Physician's Naci Buyukunsal, M.D.	Springfie	ld State	Hospi	tal, Sy	kesvil	le, M	
3a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY	OR CREMATORY	23d. LOCATIO	ON (City, to	wn or county)	(:	State)	
Burial 2-25-62 F'bg.Memor:	ial Park	Fro	stbur	g.	M	d.	
4 FUNERAL DIRECTOR'S SIGNATURE ADDRESS		C'D BY REGISTRA					
Joseph R. Alugst Frostburg,		EB 2 7 '62	0	othur S. H	Taua		

3 6 4 8 6 3 C 477 THE STATE OF THE PROPERTY OF T STREET TATIONS (Trailing two) Section and The Section Section 2015 in the stocket of the first starte of the store this will be And Strong Sea, excellent the strong of the . No produced the state of the Marie L. M. spredners Committee to the

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death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

01769 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN if outside corporate limits, write RURAL and give nearest town) URAL and give hearest town) IMOre d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL (If not in haspital, give street address) STITUTION YES NO NO NAME OF Middle 4. DATE Day Yeor OF DEATH DECEASED! (Type or print) 1962 70 W/ 9. AGE (In years lost birthday) IF MINDER I YEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Months Days Hours DIVORCED [WIDOWED & 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? INTERVAL BETWEEN 18. CAUSE OF DEATH | Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Canditians, if any which gave rise to immediate DUE TO couse (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTHER MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (County) (Stote) factory, street, affice bldg., etc.) Haur a. m. While Not while at work at work p. m. 7epung 12, 1962 that (1) (we) last 21. I certify that (1) (this hospital) attended the deceased from M, from the causes and an the date stated above. 2 19 6 Z and that death accurred at saw the deceased alive an energy 22a. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. STAFF PHYS. MED. M.D. 22 PHYSICIAN'S 22d. ADDRES NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) 23g. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Loudon Park Raltimore 24. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkin 25b. REGISTRAR'S SIGNATURE 25a. REC'D BY REGISTRAR Jenkins DATEFFR 5 '62 arthur & House Road, Balt. 12 Md.

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PHYSICIAN:

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within 24 hours after

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH ハイフフの

ľ	1. PLACE OF DEATE a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland Bal to City							
Į.		rroll								
1		if outside corporate limits,	c. LENGTH OF STAY IN 16	c. CITY OR TOWN	(If outside corpora	ate limits, write RURAL	and giva nearast lown)			
-	Sykesvil	-	lyr.lldays	Baltin	more 18		3 vo1.4			
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS e.						
	- L	eld State Hosp	2701 Matthews St. ON A FARM?							
	3. NAME OF DECEASED	First	Middle	Lest	4. DATE	Month	Day Year			
	(Type or print)	Howard	Jefferson	Walters	DEATH	February	12, 19 62			
1	5. SEX 6. COLOR OR RACE 7. M		RRIED NEVER MARRIED 8	DATE OF BIRTH		AGE (In yeers IF UNDE				
1	Male	T 77 - 3 - 1 -	OWED DIVORCED	July 18, 1	884	77 yrs. Months	Days Hours Min.			
	10s. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman						U.S.A.			
1	13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
1	Ambrose	Walters		Cather	ine Diet:	rick				
1	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address									
	(Yes, no, or unknown) (Ifyesgive wer or detes of service) 216-07-9876 Springfield Hospital Records.									
	18. CAUSE OF I	DEATH (Enter only one cause	per line for (e), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH			
ı	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senticemia									
ı	171	5 X DUE TO	2 CONTRACTOR OF THE PARTY OF TH				Days			
1	Conditions, if ony, which \ (b) Pulmonary abscesses									
I	Days									
	(e), steting the underlying DUE TO cause last. (c) Bed sores									
	cause last.	(-)		T DELATED TO THE TERM	UNAL DISEASE CO	NOTION GIVEN IN DA	PT 1(a) 19 WAS ALITOPSY			
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTO PERFORMED. PERFORMED YES NO									
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. C. B. S. assoc. with cerebral arteriosclerosis with psychotic reaction. YES 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)									
	Hour e.m. While Not While lactory, streat, office bldg., etc.)									
	21. I certify that (I) (this hospital) attended the deceased from January 31, 1961, the bruary 12, 1962, that (I) (we) last saw the deceased alive on February 12162, and that death occurred at 1:30P. From the causes and on the date stated above									
	22a. SIGNATURE		0	ATTENDING	MED.	STAFF	22b. DATE			
	Gar	who del	Christo M	Transport T	DIRECTOR [PHYS.	2/12/62			
	22c. PHYSICIAN'S NAME (Type	Agustin del	- 1/2 -	Springfield State Hospital, Sykesville, Md						
	23a. BURIAL, CREMAT	ION (City, town or cou	inty) (Stete)							
	Burial (Specify)	2-16-62	New Cathedr	al Cemeterv	Balt	imore				
1	24 FUNERAL DIRECTOR	R'S SIGNATURE	ADDRESS	25a, RI		AR 256. REGISTRAR	S SIGNATURE			
	Wm.Cook, In	c.,1217 St.Pau	l Street, Baltimo	re 2	EB 1 4 '62	arthun .	8. Thais			
				I PUIL I	-	1				

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH 01771

a. county Carrol	1.		MARYLAND	a. STAJE	b. COUNTY	titution, Residence before admission)				
b. CITY OR TOWN	b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporata limits, write RURAL and giva nearest town)						
Sykesv		· 2mos	19dys.	Baltimon	re 22	134.2.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS		. IS RESIDENCE					
Spring	field State	Hospital		ממממ	d Battle Grove	Bood YES NO W				
Springfield State Hospital 3. NAME OF First Middle				4. DATE Month	Dey Yeer					
(Type or print)	Kath	rvn Pvi	27.0	1127722	OF DEATH Polyman	0/ 10 /0				
5. SEX				Williams DATE OF BIRTH	9. AGE (In years IF					
Female	White	7. MARRIED NEVER		April 15. 189	last birthday)	Aonths Deys Hours Min.				
10a. USUAL OCCUPAT	ION (Give kind of wor	k 106. KIND OF BUSIN			& State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?				
Dishwashe		Bd)		West Virg	rinia	U.S.A.				
13. FATHER'S NAME				14. MOTHER'S MAIDEN N		U.D.R.				
Pete Pvi	Pete Pyfle _									
15. WAS DECEASED EN	5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address									
(Yes, no, or unkown) (Yes, not unkown) (Ifyesgivewarordatesofservice)									
	DEATH [Enter only one	e cause per line for (e), (b	shringi tera no	papiest necords	INTERVAL BETWEEN					
PART I, DEAT		ONSET AND DEATH Days								
71	IMMEDIATE CAUSE (a) Septicemia									
	DUE TO									
	Conditions, if eny, which gave rise to immediate cause (b) Infected bed sor					weeks				
	(e), steting the underlying DUE TO									
cause lest.										
PART II. OTHE	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?									
3 C.B.S. ε	Sis. YES NO									
E 200. ACCIDENT W	C.B.S. associated with cerebral arteriosclerosis, without psychosis. YES NO 200. ACCIDENT WAS UNDERLYING 200b. DESCRIBE HOW INJURY OCCURED. (Enter netura of injury in Pert I or Pert II of ifem 18.)									
S (IF EITHER, NOTIFY	(IF EITHER, NOTIFY MEDICAL EXAMINER)									
3 20c. TIME OF INJU	JRY Month, Day, Ye		42.1	CE OF INJURY (Home, farm,	20f. (City or town)	(County) (Slete)				
ZOc. TIME OF INJU Hour a.m.	19	While Not Whi		tory, street, office bldg., etc.)						
		ital) attended the de	ceased from	12-7- 10	61 to 2-26-	, 152., that (I) (we) last				
						nd on the date stated above.				
saw life decea	sed all ve oil	17	mai mai	death occured all.RA	A.M. Priesmantie canzez at	id oil life date stated apposet				

15M 7/61

has been signed by the attending physician and complex. Ville e burial-transit permit. Then please remove carbon papers. Pairial, cremation, or removal, and in any event, within 72 hours

The law requires that the death certificate be execu-

24 FUNERAL DIRECTOR'S SIGNATURE

230. BURIAL, CREMATION, 236. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 3. 1962 Holy Cross

Agustin del Campo, M.D.

usteri del Compo M.D.

23d. LOCATION (City, lown or county)

Springfield State Hospital, Sykesville, Md.

Fairmont, West Virginia

ADDRESS

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

JOHN J. DMDA 7922 Wise Ave. 22, Md.

ATTENDING

22d. ADDRESS

DATE MAR

162

MED. STAFF DIRECTOR PHYS.

Cichur S. Kraus

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RYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. COUNTY b. COUNTY by the and 2 death. MARYLAND Carroll Maryland Baltimore b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporete limits, write RURAL and give neerest town) write RURAL and give nearest town) days. rs. Pages hours after Sykesville Baltimore 14 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) . IS RESIDENCE ON A FARM? YES NO. NAME OF INGfield State Hospital 3020 Texas Avenue 4. DATE Month DECEASED OF Lillian Wise (Type or print) DEATH 70 62 19 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthday) Months Days Hours Female White WIDOWED DIVORCED November 23, 1883 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? 10b, KIND OF BUSINESS OR INDUSTRY | 11, BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired) Secretary Gov't .- Retired U.S.A. Maryland Then please 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Henry A. Wise Minerva E. Pifer 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address requires that the (Yes, no, or unkown) | (If yes give war or detes of service) Springfield Hospital Records INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Bronchopneumonia days IMMEDIATE CAUSE (e) Arteriosclerosis Heart Disease vears gave rise to immediate ceuse DUE TO (a), slating the underlying Generalized arteriosclerosis. vears PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 19. WAS AUTOPSY PERFORMED? C.B.S. assoc. with senile brain disease, without psychotic reaction. YES NO X 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING (X CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) Fell to the floor while trying to sit down on a foot steal (County) (State) 20c. TIME OF INJURY Month, Day, Yeer 2Dd. INJURY OCCURRED I 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) Not While While 12-27, 61 at work at work X Hospital Carroll Md. Sykesville 19 61 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on..... DATE SIGNED ATTENDING PHYS. DIRECTOR 22d. ADDRESS PHYSICIAN'S NAME Type Springfield State Hospital, Sykesville, Md. Agustin del Campo. M.D. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, 0 = 3 REMOVAL (Specify) RIAL 250. REC'D BY RECISTRAR 256. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S VR A15 (4) 1SM 7/61 DATE

